Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Date Month 12 Physician/ 2010 11:00 PM Thomasina Petersen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Nursing and Rehab Ellicott City Howard g. Birthplace (State or Foreign Country)

Ireland If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🖫 F 5/2/1913 220-12-9045 97 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director notified West Friendship MD Howard 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10q. Citizen of What Country? ъ Examiner must be 23a Funeral 2305 Pfefferkorn Rd. 21794 United States items 2 death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 ☐ Never Married 2X Married ō by Maryland 21215-0036 after 1 Yes 2 No Specify: Specify: White If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Unknown Thomas Armstrong traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shr Department of Health an Important; If item 27 is any injury or other trau once. 2305 Pfefferkorn Rd. West Friendship, MD 21794 Hans Petersen - Husband Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🗌 Burial 2 💢 Cremation 3 🗍 Removal from State Ardent Cremation 12/4/10 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate deno Carcinoma Immediate Cause (Final hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-1 Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death ed by the detached Unknown g Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has t autopsy performed? Yes 2 2 No Physician; The certificate 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical E'Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30641 Back RIVER Neek Road Baltimox Mayles 30. Name and address of person who completed cause of cleath (Item 23a) (Type, Print) abapalhi 201-109 amesh 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Richardson Peirce Jr 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICOMICO TENINSUVA If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) PA. 1 🔀 M 2 🗆 F Days Hours 74 (Month, 24, 136) 173-28-8914 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits ortant, If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director DE Kent Milford 1 🗌 Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19963 US 2665 Canterbury Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Year or Dates. 55-59 Specify: 3 Divorced 4 Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Oil Co. Safety Director 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Richardson Peirce Virginia MAy Grimm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty A Peirce/Wife 2665 Canterbury Rd., Milford, DE 19963 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Crem. Center 12/3/10 Millsboro, DE 22. Name and Address of Facility
Rogers Funeral Home Inc
301 Lakeview Ave., Milf Signature of Funeral Service Licenses J. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MUTPLE CLEAN FALURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 3 WEEKS anc. VANE REPLACENENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine YENRS To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events ADRIC SPENISIS Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Ceryping Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) 1)RC 02, 200

Registrar
DHMH 17 Rev 7/2009

State

30. Name and addr

31. Date filed (Month, Day, Year)

3

person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

10-09172 Lynn M. Pennewill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

III IVI. I CIIIICVI		1- For State Constant of Certificate of	Death	Reg. N	No.		
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death		
		Lynn M. Pennewill			November 29, 2010		
)-x		4a. Facility Name (if not institution, give street and number)		4c. County of Death Wicomico			
,		Peninsula Regional Medical Center		(0)			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	- '	MM/DD/YYYY) 9. Birth Foreigr		
Director		212-40-9246 1 M 2XF 69 Yrs		12 02 1	940 cou	ntry) Maryland	
		Usual Residence of Decedent				10d. Inside City Limits	
* any		10a. State 10b. County 10c. City, Town or Locat	ion			1 Yes 2 X No	
and f shov	5	Maryland Wicomico Eden					
Maryl 28a-1 d at c	Director	10e. Street and Number	10f. Zip Code		Citizen of What Coun	ry?	
1 the 38 or	ﻕ	986 McGrath Rd.	21822		5A		
h witl ems 2 t be n	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	is Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,	
or ite	듄	1 Yes 2 K No	V		Specify: Whi	to	
s after ral",	þ	3 X Widowed 4 Divorced If Yes, Give Year 1 1 1 15. Decedent's Education (Specify only highest grade completed) 16a. Deceder	Yes 2 X No specify: "It's Usual Occupation (Give kind of v	vork done	b. Kind of Business/Ir		
hour fratu	ted		ost of working life. DO NOT use reti			,	
36 tin 72 than dical	ple	12	ine Cooretary	177	S Governme	nt-	
d with	Completed	17. Father's Name (First, Middle, Last)	ive Secretary 18.Mother's Name	(First, Middle, Maid			
21215-0036 Mental Hygien 72 hours after death with the Maryland Mental Hygien marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.	Be	William McGrath	Grace L	ambertson			
212 Suld b Men mar	To	19a. Informant's Name/Relationship (Type, Print)	g Address (Street and Number or I	Rural Route Number		Zip Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.			cGrath Rd., Eden				
e, lead Healt Healt Litem			sition (Name of cemetery, her place)		oc. Location - City or		
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1 X Burial 2 Cremation 3 Removal from State Crematory or of Zion Ceme	tery 12	04 2010	Eden, Mary	land	
Baltir permit. F Departme Importatinjury or		21 Signature of Europeal Service Licenses	Name and Address of Facility	omo P A			
M F F F F	2.3	150 150	lloway Funeral H l Snow Hill Rd.,	Salisbur	y, Marylar	nd 21804	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval					
Modical	22	failure. List only one cause on each line. Immediate Cause (Final disease a. Pulmonary Thromboembolism Death					
Examiner		or condition resulting in death) Due to (or as a consequence of):					
	<u>.</u>	Sequentially list conditions, if any, leading to historicalists b. Bilateral deep vein thrombosis Due to (or as a consequence of)					
	nin	cause. Enter Underlying Cause					
r di	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
Division of Vital Records, P.O. Box 68760, To the Bospial or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		d.					
60, ate be ex hysician le burial	Medical	UNPENDED			2010		
376(ficate g phy s the b		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	etal death 3 Ectopic pregn.		23d. Date of delivery Month D	ay Year	
c 68 certi endin use a	ciaı	past 12 months?	ther (Specify)				
Box 687 e death certific the attending p ed for use as the	Physician/	1 Yes 2 No 9 Unknown g Unknown					
od by the etache	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		yes 2 No 3 Probably 4 ✔ Unknown		
signe isigne		Metastatic vaginal carcinoma					
v request property	Completed			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of	
ecc he lav ate ha	E C			performe 1 V Yes 2	d? death? No 1 ✓ Ye	s 2 No	
m: T ertification, p	Bec	25. Was case referred to medical	26.Place of Death (Check				
Vit; hysici this co	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient			sidence 6 Other		
Division of Vital Records, P.O. rat or Actions of Wital Records, P.O. at or Actualing Physician: The law requires that it at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	<u> </u>	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of		28d. Describe how	injury occurred		
ion tendi cath. tor:	atio	1 V Natural 5 Pending 2 Accident Investigation	1Yes 2No				
or At after d	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	et, factory, office building, etc.	28f. Location (Stre or Town, State		al Route Number, City	
Spital nours filled	Se	4 Homicide determined (Specify)					
Division of 'To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After completely filled in by the funeral		29a. Certifier (Check only one) Medical Examiner: On the bast of my knowledge, death occurrence) Wedical Examiner: On the basis of examination and/or investigation.	rred at the time, date and place, and tion, in my opinion, death occurred	due to the cause(s at the time, date and) and manner as state i place, and due to the	ed. e cause(s)	
To th withi To th	Medical	and manner stated.	29c. License number		9d. Date signed (Mor		
	2	29b. Signature and title of certifier	O.C.M.E.	1	November 30, 20		
10.		(alund / Gitel)					
Clark		30. Name and address of person who completed cause of death (Ilem 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 21	201			
V	tate						
Regis		ill i'd o 'hitai					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#5 per FH, 12/8/10, BMW, McCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2010 Charles Mack Rodgers November 27, 12:35 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) July 6, 1925 7. Age (In yrs. last birthday) 5 Social Security Number 230 - 4246 **Funeral** Months Hours Davs 1**X** M 2 □ F Virginia Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County works other traumatic evant, the Medical Examiner must be notified at 1 Yes 2 No MD Montgomery Siver Spring Director 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with ō USA 20904 2501 Musgrove Road "natural", or itams 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or itams 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 No 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates: 1943–46 Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Security Guard 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Wommack David Rodgers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 3748 Forest Haven Drive, Richmond, VA 23234 Ollie Rodgers-Mayo / sister 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Metropolitan Crematory Dec. 2, 2010 Alexandria, VA ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility CMGA Francis J. Collins Funeral Home, Inc. 500 University Blvd. West, Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate Enter Inderlyin, Cause (Disease or injury Due to (or as a consequence of): Examiner ia-transit the death certificate be executed Hemoptysis resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician buri Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy 2 | Fetal death Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2 ☐ No P.0. detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, à should be Colon Cancer 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2**X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes il or Attending Physician: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Iri by t 4 Homicide To the Hospital
within 24 hours a
To the Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Su

Road

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10810 Darnes

03 2010

31. Date filed (Month, Day, Year)

round

29d. Date signed (Month, Day, Year)

D19609.

December 2, 2010

RAMAN 202 Gar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 4:00 Clara Amelia Riggs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Denton Homestead Manor Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) ay 26,1923 1 □ M 2 🛣 F Days Months Hours Country) Director May 482-24-1040 87 Owa Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🗓 No Dent<u>on</u> Marvland Caroline 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral U.S.A. 24190 Saulsbury Road 21629 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in U.S.

Armed Forces?

1 △ Yes 2 □ No 1944

If Yes, Give to 1945 Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: d Mental Hyglene. marked other than "natural", White 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Government Contracts Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Goraczkowski Victoria Korolawski permit. Page 1 and 2 should be Department of Health and Men Important, If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy K. James/daughter 24190 Saulsbury Road, Denton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 📥 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Capitol Crematory Dec. 7, 2010 Dover, Delaware 21. Signature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. Denton, Maryland South Second Street. 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. erval Between Onset and Death Immediate Cause (Final Physician myocardial 2/9-903 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ocover Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit 10 lactes mell Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ♠No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 325 13 2005 3

DHMH 17 Rev 7/2009

State

Registrar

Ledn.

in Ave Proston MD 2165

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 6 20

Regis

31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 10a,b,c,d,e, per fb 2911.01/12/2011dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Frances Ricketts 2! 35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5 omic If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🖸 F Months Min Hours DF. Country) Director 214-32-5625 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Sussex Seaford THES 2 NO DE Kont Dover Oe. Street and Number 603 Woodland Mills Dr. 10f. Zip Code 10g. Citizen of What Country? 19973 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ ☐ Yes 2 X No Mary Ricketts Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Nanticoke Memorial Elementary/Seconday (0-12) College (1-4 or 5+) 10 Housekeeping Hospita] Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Ricketts Fannie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) oanne Gibson/Cousin Frear Drive, Dover, DE 19901 20a. Method of Disposition 20b. Place of Disposition (Name of LLC) cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Direct Crematory, 2-7-2010 Dover, DE Bennie Address of Facility 917 W. Isabella St. uneral 5 Salisbury, MD 21801 Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LIURA CARCINOMA MAHENANT disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and-tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specity) ___ in the past 12 months?

1 Yes No
9 Unknown Month Day Year ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 2 100 1 Yes 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: 2/ No ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence Hospia this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated eritifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B00 Husty 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40007 Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12 08 2010 4:30 AM RUTH ELIZABETH SPATES 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Frederick Frederick Northampton Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 08 08 19 Birthplace (State or Foreign Country) Ohio 5. Social Security Number 7. Age (In yrs. lest birthday) Months Days Hours 1□ M 2 KF Yrs. 1919 213-10-9737 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. Stete Allegany Frostburg 1 MYes 2 □ No MD 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code U.S.A. 21532 78 Frost Avenue 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status Black, White, etc. 1 □ Yes 2 ANo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Own Home Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Enoch Logsdon Edna Logsdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2100 Wayside Drive 2B Frederick, MD 21702 Patricia Chaney daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Michael's Cemeterv 12-11-10 Frostburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sowers Funeral Home, P.A. MU0547 Frostburg, MD 21532 Jowes 3 60 W. Main Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death MONTHS DEMENTIA Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Tys 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 2 Accident Injury

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral Director

Be Completed by

Funeral

Director

ician/Medical Examiner After this certificate has been signed by the ettending physicien end funeral director, page 2 should be deteched for use as the buniel-transit

X
듄
Ď
Completed
Be
ဥ
Certification:
Medical

or Attending Physician: The law requires that the death certificate be executed

Phys	
by	
eted	
dmo	
ပ္သ	
o B	
Ë	

3 Suicide

29a. Certifier (Check only one

29b. Signatu

4 I Homicide

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral

Registrar

State

PLAYEEN B-LALUN 31. Date filed (Month, Day, Year)

d title of certifier

6 Could not be determined

196 TJ Dewe Aegistrer's Signature recen

and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D0062223 30 Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dev. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

PREDELICK, MD-21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 1120 A^{M} December 10 2010 Audrey May Sickles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Ceci1 E1kton Elkton Care and Rehabilitation If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 16, 1939 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min. Months Days Hours 1 □ M 2 🛱 F Mary land 217-36-3160 71 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21921 126 West Thomson Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 MiNo If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 □Yes 2 🗓 No Specify. Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) In Her Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aldine Starkey Edgar Basham ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 126 West Thomson Drive, Elkton, MD William G. Sickles/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 13, 2010 West Chester, PA R. A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 usmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Kespirator. disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Injury

The law requires that the death certificate be executed and burial-trar physician the burial Box 68760 attending ph for use as the signed by the a Ö σ. Records. ate has bage 2 s certificate Division of Vital or Attending Physician: this funeral After t the Funeral Director: Af the Hospital

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

28a-f show

Certification:

cal

1 Natural 2 Accident 5 Pending investigation 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
21 Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of per completed cause of death (Item 23a) (Type

Registrar

(ark

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#28 openMD, 12/9/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11729/2010 Anna May Flynn Smith 1:25A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Bethesda Suburban Hospital Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months 1270971912 Maine Director 97 029 01 6085 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 5101 Ridgefield Road 20816 'natural", or items 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify.White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry ant of Health and Mental Hygiene.
If If them 27 is marked other than "n. or other traumatic event. *** Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental i Important: If Item 27 is marked c any injury or other traumatic eve ance. Maura Hurley Maurice Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Wolf/Attorney 4901 Montgomery Lane Bethesda, ND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory | 12/03/2010 Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licensee Washington, DC 20016 5130 Wisconsin Ave., NW 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one c ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Severe Dysphagia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Multiple Bilateral Subacute Infarct Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica gompleted filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 11/20110 66264 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Bethesda, MD 3600 014 Georgetown Registrar's Signaty State MEC 03 2010

DHMH 17 Rev 7/2009

Registrar

Smith Ama M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMFND #5 per INF, 12/9/10, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ December 1, 2010 Helen Spera Sestito 2:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sunrise of Montgomery Village Montgomery Village Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F July 6 1919 Connecticut Director 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Montgomery 1 Yes 2 X No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20878 17605 Parkridge Drive United States oe filed wm....
Aental Hygiene.
-vent, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. White Specify. Completed 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked o ဂ traumatic John Gregory Josephine Marino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Annette Spera Thompson/Daughter 17605 Parkridge Drive, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fairfield Mem. Park 12/11/2010 Stamford, CT 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home Mª Millian wan MO1202 | 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Mins Medical Due to (or as a consequence of) **Examiner** Yrs Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that the death certificate be executed as the burial-trup that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) 1 🗌 Yes 2X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending work? 1 ☐ Yes 2 ☐ No Division within 24 hours after death.
To the Funeral Director: A completed filled in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Gertifying Nurse Practioner: Title best of my including and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: Title best of my including death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suhair H. Abulfarag,

31. Date filed (Month, Day, Year)

D31391

MD, 604 South Frederick Ave., #413, Gaithersburg, MD 20877

December 2, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 2010 Month Physician/ 3:30 AM Schutt December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Maryland MedicalCtr Baltimore N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Auq 9 Day, 1927 Months Days Hours XXM 2 D F 83 Director 091-20-7837 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d, Inside City Limits 10h County within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Completed by Funeral 20905 USA 2403 Peach Stone Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1945 If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) 12 should be filed within 72 lith and Mental Hygiene.
27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Chemical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Zanetta Campbell Merton Schutt t. Page 1 and 2 should by tment of Health and Mer tant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Silver Spring, MD 2403 Peach Stone Ct. Uta Schutt permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Ardent Cremation Ser. 12/3/2010 Hanover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of FaciMarry H. Witzke's Family F.H. Inc. Signature of Funeral Service Licenses olu K 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final NON SMALL CEll LUNG CANCER enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending physic I for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23h. Was decedent pregnant Live Birth 2 Tetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown the Hospital or Attending Physician: The law requires 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No cate has l page 2 s 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ပ After thi funeral 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural work? 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 22980 December 2, 2010 ennie M.D.

Registrar
DHMH 17 Rev 7/2009

State

South Greene Street

32. Redistrar's Signature

neura

Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2010

J.ennie Law M.D.

31. Date filed (Month, Day, Year)

DEC 0

10-09492 Michael Taylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

ilcilaei raylor		1- For State Registrar	ate of Maryla	-		of Death	nd Wenta		Reg. No.	10 40012
Physic		Decedent's Name (First, Midd						2. Date of Dea		3. Time of Death
Medical Exam	iner	MICHAEL AT 4a. Facility Name (if not institution	NTHONY TAY			4b. City, Town, o	or Location of D		er 10, 2010 4c. County of	
					North Eas	t		Cecil		
Funeral Director		5. Social Security Number 138-80-3401	6. Sex	7. Age (In yrs. I		If Under 1 Ye Months Da Yrs.		14:-	rth(MM/DD/YYYY) 9/1985	9. Birthplace (State or Foreigr C 仍时取 TSTIANA DELAWARE
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation			_	10d. Inside City Limits
*	ក	MARYLAND CEC	IL		NORTH	EAST				1 Yes 2 No
death with the Maryland or items 23a or 28a-f she must be notified at once	Director	10e. Street and Number 5 MORGAN COUR	Γ			10f. Zip Code 21	.901		10g. Citizen of What UNITED S	•
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mendal Hygiens them 27 is marked other than "natural", or items 23a or 28a-fain traumatic event, the Medical Examiner, must be notified at once	Funera	11. Marital Status 1 XX Never Married 2 M 3 Widowed 4 Div		2 X No		Vas Decedent of H	an, Mexican, Po	? (Specify Yes or No uerto Rican, etc.)	14. Race - White, Specify:	American Indian, Black, , etc. WHITE
iours af intural	ed by	15. Decedent's Education (Spe	or Dates: cify only highest grade	completed)		ent's Usual Dccup most of working lit	ation (Give kind		16b. Kind of Bus	
36 thin 72 h ee. than "v	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)		_	. DO 1401 us	o retired)	4.001	TANGE
5-00 ed with tygiene other t	Com	$\frac{1}{1}$ 17. Father's Name (First, Middle,	, Last)		KEI	PAIRMAN	18.Mother's N	Name (First, Middle,		LIANCE
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaliupry or other traumatic event, the Medical Exami	Be C	ANTHONY PAUL S 19a. Informant's Name/Relations			Lage Made	: A dd 101		RICIA ANN		7.0.1
MD 2 d 2 shoul lth and M n 27 is m	To	PATRICIA A. TAN		HER				r or Rural Route Nur RTH EAST,		
re, N s 1 and f Health f item er trau		20a. Method of Disposition 1 Burial 2 X Cremation		20b.		osition (Name of c	emetery,	Date DECEMBER		City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other 8	opcity.			LE CREMAT	ORY 1	17, 2010		DELAWARE
Balt permit Depart Impor injury		21. Signature of Funeral Service	Licensee					ROUCH FUNI		E MARYLAND 21901
Physician		23a. Part I. Enter the disease, or failure. List only one cause		used the death						
/Medical £xaminer		Immediate Cause (Final disease or condition resulting in death)	a Methado			done int	oxicati	on		Death
		Sequentially list conditions,	Due to (or as a ob.	consequence o	f):					
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	consequence o	f):					
ecuted and - transit	l Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence o	f):					
50, ite be exec nysician a e burial - t	dica	XUNPENDED	☐ AMENDED 23a	.27.28a	-f.per	ME G910	12/22/	'10 TT		-
Division of Vital Records, P.O. Box 68760, the Boopital or Attending Physician: The law requires that the death certificate be executed thin 24 brows after ctors. The Puneral Directors. The Puneral Directors. After this certificate has been signed by the attending physician and npletely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live bir	MENDED 23a, 27, 28a-f, per ME G910 12/22/10 TT 3c. If yes, outcome of pregnancy Live birth 2 Fetal death 5 Other (Specify) Unknown				23d. Date of d Month	lelivery Day Year	
D. B. It the de by the		Part II. Other significant condit			esulting in the	underlying cause	given in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?
F, P.C.	d by							1Yes	s 2 No 3	Probably 4 V Unknown
Records The law requires the law requires the last page 2 should	ompleted			_			····_	24a. Was autop perfo 1 V Yes	osy pri rmed? de	ere autopsy findings available for to completion of cause of eath? Yes 2 No
tal Recition: The certificate	BeC	25. Was case referred to medica examiner?	Hospital:				of Death (Ch			3
of Ving Physican After this	-T	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatie 28b. Time o		ury at Work?		Residence 6 🗹	
ion (tending eath.	ation	1 Natural 5 Pending Ed 12/10/10 Ed 8:45 am 1 Yes 2 X No unk								
Natural Specify Found Specify Specif						or Town, S	ation (Street and Number or Rural Route Number, City own, State) 5 Morgan Ct ch East, MD			
o the Horithin 24 h	edical (miner: On the best of	examination a						
and manner stated. 29c. License number 29d. Date signed (i)						(Month, Day, Year)				
	O.C.M.E. December 11, 2010						1, 2010			
		 Name and address of person Jack Titus MD. Dep 	who completed cause outy Chief Medica	,		enn Street, Ba	Itimore, MC	21201		
Si Regis		31. Date filed (Month, Day, Year)	7 2010 32.R/g	istrar's Signatu	ire					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 28, Anne W. Taylor 2010 09:09AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Clinton Southern Maryland Hospital **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Hours 1 DM 2 X F 1213171921 Director Maryland 88 219-05-3859 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 ื No Snow Hill Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21863 111 South Collins Street USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed Black Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other fraumatics. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teaching Home Economics Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Johnson James L. Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5541 Shallow River Rd., Clinton, MD 20735 Lauraetta_Hurst | daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ebenezer Church 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12 04 2010 Snow Hill, Maryland Cemetery graure of Funeral Service \$22. Name and Address of Facility
Stewart Funeral Home West Rd., Salisbury, MD 21801 art 1. Enter the disease, or complic at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for t Month Day Pregnant at time of death the a 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No Completed 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performe certificate has within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

2

State Registrar 29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:38 Charlotte Theresa Vardy 11 30 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Ocean City 10117 Keyser Point Rd. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08 12 1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Mary Land 1 □ M 2 🕱 F Director 218-03-3248 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County d other than "natural", or items 23a or 28a-f shovevent, I'm be client Examinating at 1 XYes 2 No Maryland Worcester Ocean City Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 21842 10117 Keyser Point Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □NO Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Alice Kavanagh William Lambie ပ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 27 Boston Dri., Berlin, MD 21811 Charlotte Ellen Vardy|daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Salisbury Crematory or other place) 12 02 2010 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home P.A. Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 Drene 23a. Part 1. Enter the disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one crust on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neum on a 1 Rek **Physician** /Medical D e to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year for 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.O. 9 ☐ Unknown is been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 HNO certificate 1 ☐Yes 2 🗷 No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗀 🕶 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0059945

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

barka

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).
Kristine M. G. Hon, 33145 Lighthouse Road, Suite 6, Selbyuille, Delaware 1997)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 Nov 10 Katherine G. Wyatt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 10103 Chickadee Lane Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. May 31, ^{Ye} 1915 1 M 2 X F 274-20-1811 Georgi Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland Director Hyattsville 1 X Yes 2 No MD Prince Georges 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral USA 20783 10103 Chickadee Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Decupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer/School Teacher Private Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Florida Middleton Johnny James Wyatt . Page 1 and 2 should b tment of Health and Me **tant: If item 27 is mark** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10103 Chickadee Lane Hyattsville, MD 20783 <u>Ruby Hammond/ Niece</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or George Washington 12-08-2010 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home 20011 21. Signature of Funeral Service Licenses 3831 Georgia Ave. N. W. Washington, D. C. cc0278 23a. Part 1. Enter the disease, or dein nications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Alzheimers Dementia Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to in modistic cause. Enter Underlying Cause (Disease or iinjury Examine District or as a consultance of or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page 2 Yes 2 perform 1 Yes 2 No After this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 🔀 No Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 \square Pending Natural Investigation Accident fter death 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours of To the Funeral Di Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D41182 12/1/2010

State Registrar

31. Date filed (Month, Day

3/2. Registrar's Signature

Felton Anderson, MD 8507 Oxon Hill Rd. #102 Ft. Washington, MD

20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month NOV 2010 29 LYLE HARRY WHIPPO 11:50 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Days August 20, 1929 New York Director 116-20-6179 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Gaithersburg Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States of America 9 Chestnut Street #102 20877 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 X Yes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Specify: White r Yes, Give Year or Dates.1948-68 Completed 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic during most of working (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Retail Business Owner Clocksmith 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Margaret Gronquist Harry Whippo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chestnut Street #102, Gaithersburg, MD 20877 Kyoko Whippo - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 12/08/2010 Brentwood, Maryland Lincoln Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Cremation 21. Signature of Femeral Service Licenses 1040 Rockville Pike, Rockville, MD 20852 MO1294 Wat Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗌 No Yes 2 X N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 XNo မ 1 Tes 1 Kinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🗷 Natural work? 5 Pending 1 🔲 Yes 2 🗌 No Investigation Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatule and title of certifie 6+1 0101242259 (VA)

Registrar
DHMH 17 Rev 7/2009

State

JAMES

Ε.

03

31. Date filed (Month, Day, Year)

USN

MC

32. Registrar's Signature

LT

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

STANTON, III

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 16000M WATERS AGNES Medical 4a. Facility Name (if not institution, give street and number) 4c, County of Death 4b. City, Town, or Location of Death **Examiner** Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Min. 1 □ M 2 🗙 F 213-44-0557 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sl aumatic event, the Medical Examiner must be notified MI 1 Yes 2 No UDRIR 10g. Citizen of What Country? 10e. Street and Numbe Funeral 27830 USA 21867 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. Armed Forces 1 Never Married 2 Married 2 1 ☐ Yes : If Yes, Give 1 ☐ Yes 2X No Specify. Spec B: lack 3 🗌 Widowed 4 🔲 Divorced Completed Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) University of MD College (1-4 or 5+) Elementary/Seconday (0-12) Administrative Assistant | Eastern Shore Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Magdalene Collins James Handy, Sr. 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27830 Jim Moore Rd, Upper Hill, MD 21867 Theodore P. Waters, Sr Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Handy's Donation 5 Other (Specify) 12-4-2010 Upper Hill, MD Fam Cem Signatur uneral Service Licensee 22. Name and Address of Facility 917 W. Isabella St Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ar shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CARDIOUSCULAR Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (o) as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events as a consequence of resulting in death) Last Be Completed by Physician/Medical division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 Q 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 🔀 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 NOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation after death Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 **Description Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) M. Boldede > Xelen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

541-F RIVERSIDS DRIVE SAUSBURY W.D. 2186,

Registrar DHMH 17 Rev 7/2009

7

anes

32. Registrar's Signature

RIVERSING

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 24 - 2010 1:26 AM Heyder George Zeibel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Coastal the Lak Salisbur Hospice at Wicomico Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min. 1 X M 2 □ F 189-01-9714 93 Director Sept. Iowa Usual Residence of Decedent 28a-f shov 10a State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1700 Riverside Drive U.S.A. 21801 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Marylanc 21215-0036 1944-If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify and Mental Hygiene. is marked other than "natural", Specify: 3 Widowed 4 Divorced Completed 1946 white 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nutritionist Poultry Feed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Anthony G. Zeibel Ida Heyder injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Mary F. Zeibel (Wife) 1700 Riverside Drive Salisbury, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 70 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 11-25-2010 Delmar, Delaware Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee any 13 East Grove Street Delmar, DE 23a. Part 1. Enter the o shock, or heart fa sease, or complications that oure. List only one cause on ea sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death DISRASE Pnysician/ LZHRIMRA disease or condition Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) ttending physician Physician/Medical Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2/ENo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform Yes certificate 1 🗌 Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A ☐ Accident Investigation 6 Could not be the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cortifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier IVP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Mar		artment of F			giene Reg. N. 0	0	10019
Physic	ian	1. Decedent's Name (First, Middle, Las					2. Date of De Month	ath Day	Year	3. Time of Death
/Med		MARLENE D	ASPELM	EIER			DECEMBE	R 16 2	2010	18:45PM
Exami	iner	4a. Facility Name (If not institution, give		CCA1 CT TO	4b. City, Town, or	Location of D	Death	4c. County	of Death	
Funera		5. Social Security Number 6. S	1	In yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th	9. Birthp	lace (State or Foreign
Directo				65 Yrs.	Months Days	Hours	Min. 8. Date of Bir (Month, Da Feb. 7	, 1945	Coun	MD MD
pu .		Usual Residence of Decedent 10a. State 10b. County		0c. City, Town or Lo					140	0d. Inside City Limits
e Maryla 3a-f sho	ctor	MD Balti		oc. City, Town of Lo	Baltimo	re				1 ☐ Yes 2 📉 No
ath with th 23a or 28 ust be no	Funeral Director	North hozelwo	7 ood Avenu	е	10f. Zip Code 21	206		10g. Citizen of V	What Count SA	try?
Baltimore, Maryland 21215-0036, permit. Pages 1 and 2 should be filed within 72 hours at fer death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" o'r items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Furse	1 Narital Status 1 Never Married 28 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2½ No	ispanic Origin In, Mexican, P Specify:	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Rac Blac Specify	ce - America ck, White, e v: Wh:	
21215-0036, and within 72 hours af figiene. er than "natural", or the Medical Exami, the Medical Exami	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of l)	f working	16b. Kind of Bu		lustry
Hygier there the	ပိ	12th		пон	nemaker	40 Mathada	Name (First, Middle,	Own		
Maryland of 2 should be file th and Mental Hy 27 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Last) Walter Nagra					roline L			
and 2 sho leath and m 27 is method		19a. Informant's Name/Relationship (Robert Aspelme:	• • • • • • • • • • • • • • • • • • • •				or Rural Route Numb ${ m lwood}$ ${ m Av}$.MD21206
Baltimore, Dermit. Pages 1 ar Department of Hea Important: If item; any Injury or other once.		20a. Method of Disposition □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	nemoval irom State	20b. Place of Dispo			Date 2 / 2 0 / 1 0	20c. Location -		
Baltimo permit. Page Department (Important: If any Injury or		21. Signat re f Frineral Service Licen	and for		2. Name and Addres		2/20/10 300 Mace	Balti		
and per one	1	Fature R.	1 em				neral Ho			
- Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the one cause on each line.	e death. Do not ent						Approximate Interval Between Onset and Death
/Medical Examiner	Н	resulting in death)	Due to (or as a c	onsequence of):						
ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as a c	onsequence of):						
876057 cate be executed ohysician and the burial-transit		that initiated events resulting in death) Last	c Due to (or as a c	onsequence of):						
876 icate to physic the b	dica		.d						-	
Division of Vital Records, P.O. Box 6876057 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	у			ite of delive onth	ery Day Year
1S, P. res that t signed by be detac	þ	Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	nderlying cause give	en in Part I.				ne cause of death?
aw requi	Completed						24a. Was	an 24b.	Were auto	psv findings available
The late had ate had bage?	Į į						— auto perfo 1 □ Yes	rmed?	prior to cor death? 1 🗆 Yes	mpletion of cause of 2 □ No
/ita	Be	25. Was case referred to medical examiner?					Death (Check only of	- 1		
of V Physic This o		1 ☐ Yes 2 🕱 No		2 ER/Outpatier		4 LI Nursi	ing Home 5 ☐ Resi			у)
ion (ath. r: After re funer	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury Work?				28d. Describe how injury occurred			
Division of Vital Records, al or Attending Physician: The law requires the atter death. I Director: After this certificate has been signed in by the funeral director, page 2 should be of	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (St City or Town				treet and Number or Rural Route Number, n, State)			
e Hospit 24 hours e Funera letely fille	Medical (ysician: To the best of r niner: On the basis of ex and manner stated	camination and/or in						
To the vithin To the comp	Me	29b. Signature and title of certifier	0		29c. Licens			29d. Date signe	d (Month,	Day, Year)
		Hor lin	\mathcal{L}		RES.	-000		DECEMBER	R 10	6 2010
6		30. Name an dress of person who	completed cause of deat	h (Item 23a) (Type,	Print)	1-) let '	44 5 2 13	24	
		PAYAM MOHASSE	_ MD - 49	40 Easte	rn Hven	ne 5	MINOTE,	MD ~14	T	
St Regist	ate trar	TFC 2.0 2010	Augustial's	A. Sar	les .		suttinore,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per Phy G910 12/20/10 JH JH Amend #1 Per Phy G910 12/20/10 JH JH Amend Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Royston Brown, Sr. 3. Time of Death Physician/ Month 6:30M 2 Medical if not institution, give street and numb Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day,) 04 30 Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 220-12-2983 **Funeral** Year) 1 XM 2 - F Months Hours 84 Director MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Direct 1 ¥ Yes 2 ☐ No MD NA Baltimore 10e, Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral 23a 21215 3810 Copley Road U.S.A. items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc or þ 1 Never Married 2 Married Yes 2 No Yes, Give within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. Black Specify: "natural", 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Aderdeen Proving (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Ground 12th grade Civilian Military Police na permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lelia Hall William Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Copley Road, Baltimore, 21215 <u>Linda Carter-Daughter</u> Md Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 12/20/2010 Owings Mills, Md 21. Sig atur of/Funeral Service Licenses/ March Afrant West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one call on each line. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last bunial-t attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death ed by the a 2 No 9 Unknown g 🗌 Unknown P.O. sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🗌 No 1 Yes notion. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work' 1 Yes 2 No Investigation 6 Could not be 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

(Check

only one)

29b. Signature and title of

30. Name and address of

2 ...

2

DHMH 17 Rev 7/2009

person who completed cause of death (Item 23a) (Type, Print)

32.

r's Signatu

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 30 **Physician** Goldie Ellen Brown December 16,2010 /Medical 4b. City, Toyyn, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Unde Date of Birth (Month, Day, Y eb. 25, Birthplace Country) 5. Social Security Number Age (In yrs. last birthday) . 193<u>5</u> **Funeral** Months Hours Days 1 □ M 2 🔀 F 75 Feb. Virginia Director 163-30-5788 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Harford Maryland Street 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö "natural", or Items 23a 21154 3230 Old Forge Hill Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Black, White, etc. should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 21X No Specify ş 3 ☐ Widowed 4 ☐ Divorced White Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Record Keeper Accounting marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Van Buren Brown Lucy Belle Blevins ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Joines / Sister 3230 Old Forge Hill Road, Street, Maryland 21154 Important: If item any injury or othe 20c. Location - City or Town, State New Freedom, permit. Pages 1 a Department of He 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Gremation 3 4 Donation 5 Other (Spec om State New Freedom Cemetery | 12/21/2010 Pennsylvania 22, Name and Address of Facility re of Fur 21. Signati McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 tions that of Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or completions that shock, or heart failure. List only one cause on sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** resulting in death) /Medical Due 1 as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician. The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) physician a Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 D Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2 No the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by OSMANNY 1 ☐ Yes 2 ☐ No 3 Probably 4 Mknown Were autopsy findings available prior to completion of cause of death? 24a. Was an las 2 s certificate had rector, page 2 autopsy performed 2 🗆 MG 2 No 1 🗌 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 W this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print MIVER de 60ec CWI) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Barks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ Susan D. Belcher 10 2010 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1.4: Franklin ROS Ba more Squa H05 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, May 25 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🗶 F Days Hours Min. Country) 216-94-2989 46 1964 Director MD Usual Residence of Decedent or 28a-f shov 10a. State 10b County 10c, City, Town or Location 10d. Inside City Limits death with the Maryland event, the Medical Examiner must be notified at Director Middle River MD Baltimore 1 Yes 2 No 10f. Zip Code 21220 10e Street and Number 10g. Citizen of What Country? Funeral 7326 Greenbank Road "natural", or items 23a USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Black White etc. à 1 Never Married 2 Married Yes 2 TNO 72 hours after 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic average. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Instructional Assistant 2yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Susan Freeland Henry Frederick Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 7326 Greenbank Road Baltimore MD 21220 19a. Informant's Name/Relationship (Type, Print) Melynda S. Belcher/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Bayview Crematory of other place) 12/18/10 1 Burial 2 Cremation 3 Removal from State Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ 1. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed 05 attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No eral Director: After this certificate I filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 1 Yes 2 No ည 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending r death. 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

IC State 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Suleman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

32. Registrar's agnature

0

Registrar DHMH 17 Rev 7/2009 and

Franklin

29c. License number

Deive

Baltimore

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Belman Margaret 0432 AM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Baltimore Bayview Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 90 Hours NOV. 16, 1920 Country) 214-12-4198 MD Director Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at **Funeral Director** or 28a-f Baltimore 1 Yes 2 X No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a USA 5 Fairway Road 21221 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 1 Yes 2 No Specify. White Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) own home Homemaker 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Schwartz MAx Mary Walters other traumatic permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam I. Dishon/daughter 5 Fairway Road Baltimore MD 21221 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) N Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Oak Lawn Cemetery: 12/20/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 MAce Ave. Balto. MD any inj once, 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Acute subdural disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be CENTIFICATION APPL 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached for Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Denentia, history of cerebrovascular accident, hyportension, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown hypothyroid 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 N 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Xnpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Dec. 11, 2010 0900 AM 1 ☐ Yes 2 XNo fall in bathroom 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1320 Windlass Or. Assisted Living facility Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier December 17, 2010 M.O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Benjamin Eldo, M.O. 31. Date filed (Month, Day, Year) 32. Registrar's State

Registrar

Maryland 21215-0036

3altimore,

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Jak. Frauere All Copies Are Legible. Amend Item 5 per FH logical Print Indelible Jak. Frauere All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 19050 **Physician** Bee Ker Decem 1310 Ruth 15 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) June 14, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) cial Security Number 6**–18–7886** 7–05–3078 **Funeral** Hours 1 - M 2XXF Maryland 87 Yrs 1923 Director Usual Residence of Decedent 12 should be filed within 72 hours after death with the Maryland is marked other the "..." 10d, Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a. State 10h Counts 1 ☐ Yes 2XXV Director Carroll Manchester Maryland 10g. Citizen of What Country?
United States 10f Zin-Code 10e. Street and Number items 23a or ner must be n 21102 3911 Calvins Twilight Way America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo 11. Marital Status ural", or iten 1 ☐ Yes XI If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXNo Specify. Specify: White þ XXWidowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) the Homemaker Own Home 12th event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any linjury or other traumatic ewone. John Schmitt Emma Gray Schmidt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21102 19a. Informant's Name/Relationship (Type. Print) 3911 Calvins Twilight Way, Manchester, Maryland Nancy M. Brockmeyer (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition Dec. 20, 1XXBurial 2 Cremation 3 Removal from State 2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature o Funeral Say e Licens 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Approximate Interval Between Onset and Death Inter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Las but tour te Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner artery Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. the þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 No Yes 2 No 1 🗌 Yes certificate 26. Place of Death (Check only one) Physician: 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Division After 1 Natural Injury or Attending 1 🗌 Yes 2 🗌 No death. Accident 24 hours after death Funeral Director: completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 2010 DELEMBER completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Mun 600 North Wolfe St, Baltimore, MD, 21287 ding

DHMH 17 Rev 1/2001

State

Registrar

10

31. Date filed (Month, Day, Year)

parker

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Day Frances Azalea Barr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TRACE RE 1) 8. Date of Birth (Month, Day, Mar. 31 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Year) 19<u>28</u> Days 1 □ M 2X F Months Min. 214-26-0335 Director 82 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🙀 Yes 2 □ No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 D Red Head Way 21078 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Public Schools <u>Buyer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Barnaby Gross Ethel May Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly K. Metcalf/Daughter 107 Country View Court, Ashton, Maryland, 20861 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of I Important: If ite any injury or ot cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Obritation 5 ☐ Other (Specify) Trinity Lutheran Cem, 12/18/2010 Joppa, Maryland 21. Signa of Funeral Service Li 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician, Septi cem, 9 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 001-DULLS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events and-trar resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death the 9 Unknown P.0. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Š cualiens 2 No 3 ☐ Probably 4 ☐ Unknown Records. 1 🗌 Yes Completed been si should l 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed? 1 ☐ Yes 2 ☐ No this certificate Yes 2 Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 \square Pending 1 🗌 Yes 2 🗎 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 7/2009

State

Wiram

Kayman

31. Date filed (Month, Day, Yelr)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Milhausto

アイグラ

M.D

32. Registrar's Signature

D 32 609

1106 Revolution St - Harrede Gran MD 21078

29d. Date signed (Month, Day, Year)

12 16110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Year Physician/ AM CIAN YOM! 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARROU 'ARROLL HOSPITAL LENTER WESTMINSTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth

July 27, 1958 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Hours Maryland Director 220-74-2178 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 🗌 Yes 2 ី No MD Carroll New Windsor 10g. Citizen of What Country? Funeral 120 S. Clear Ridge Rd. 21776 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ò 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify 3 Widowed 4 Divorced Completed White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical Is 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u> Housewife</u> Own home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glenn O. Spielman Nancy A. Sinnott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles B. Bowman Sr. 120 S. Clear Ridge Rd., New Windsor, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Middleburg Meth. Cem. 12/17/2010 Middleburg, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home and12 Union Bridge, MD 21791 6 E. Broadway, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SEPTIC SHOUR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA Examiner attending physician and for use as the bunal-transit the i

Physician/

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed Be Completed by Physician/Medical signed by t d be detach this certificate has ral director, page 2: Certificate: To After within 24 hours after death To the Funeral Director: / completed filled in by the i Medical

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):							
cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a consequence of):							
	G							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year						
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?						
	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown							
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
25. Was case referred to medical	26. Place of Death (Chec	k only one)						
examiner? 1 Yes 2 No	Hospital: 1. ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 Residence 6 Other (Specify)						
27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation		28d. Describe how injury occurred						
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
(Check 2 Medical Examin	ician: To the best of my knowledge, death occured at the time, date and place, a ner: On the basis of examination and/or investigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s) and manner stated.						

29c. License number

1838 Greene Tru RD- # 420

D00 27619

29d. Date signed (Month, Day, Year) 12.14.2010

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC

JOSHUA

MF

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BORZYMOWSKI JUSEPH J 10:00A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 87 Yrs. 9. Birthplace (State or Foreign M名列列Land Social Security Number **Funeral** 1 ★ M 2 □ F **Director** 215-14-7781 v10. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director notified Md. Baltimore City 1 X Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 3710 Lyndale Avenue 21213 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ "natural", or Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 72 al Hyglene. d other than " went, the Mer life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Assembly General Motors Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Borzymowski Rosalia Niedziecka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Borzymowski Wife 3710 Lyndale Avenue Baltimore, Maryland21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 DO Other (Tombment St.Stanislaus Cem. 18,2010 |Baltimore,Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOMYOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death i signed by the at id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peupheral vascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed page 2 certificate 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မှ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the l 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D70031 MD Vuanasan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. UNIVERSITY PARKWAY BALTIMOREMA MAHAJAN 201 VRINDA

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

20 2010

32. Registrar's Signatur

10-09544				
Fmily Blische				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mily Blische	State of Maryland / Department of He 1-For State Certificate of De	alth and Mental Hy <i>ath</i>	/giene 20 1	0 40028			
Physician/	Registrar 1. December 's Name (First, Middle, Last) Description: Desc	Date of Death Month Day Year	3. Time of Death 1457 hrs				
ledical Examiner	Emily Blische 4a. Facility Name (if not institution, give street and number) 4b. Cit	December 11, 2010 4c. County of Dea					
1	Oppor onogapouno mourous o eme	l Air	Harford				
Funeral Director	216 22 6671 — Mc	Inder 1 Year If Under 24Hrs. onths Days Hours Min.	1 c	irthplace (State or Foreign country)			
Director	216-33-66/1 1 M 2 F 19 Yrs. West of Decedent	Aug6,1991 M	aryland				
kua.	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
Aaryland 28a-f show 1.at once. ector	Md. Harford Joppa	Zip Code	10g. Citizen of What Co	1 Yes 2 X No			
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 10f. 514 Trimble Road	21085	U.S.A.	unuy.			
with the as 23a penoti	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	edent of Hispanic Origin? (Sp	ecify Yes or No- 14. Race - Ame	erican Indian, Black,			
r death with or items 23 must be no Funeral	1 Yes 2 No	ecify Cuban, Mexican, Puerto	Specify: Wh	ita			
ural", miner	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Us	2X No specify: ual Occupation (Give kind of w	ork done 16b. Kind of Business				
72 hou n "nat sal Exa	Elementary/Secondary (0-12) College (1-4 or 5+) during most of	working life. DO NOT use retir	Residen				
5-0036 ed within 72 hour 13 yigene of the "natu the Medical Exam Completed	10th Cleane		(First, Middle, Maiden Surname)	g			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Comple	Henry Emil Blische		Lisa Schuman				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		•	Rural Route Number, City or Town, Sta Oppa, Maryland				
, MD and 2 sho ealth and cm 27 is rraumati	20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date ember 20c. Location - City of				
Baltimore, cemit. Pages I au Department of He Important: If ite injury or other tr	crematory or other plants of the state crematory or other plants of the state cokes bury		,2010 Abingdon	,Maryland			
altin mit. P. partmer portan ury or	21. Signature of Funeral Service Licensee 22. Name a	and Address of Facility & a.C.	zorowski Funer	al Home, P.			
			enue Baltimore	, Md . ZIZZ			
Physician Wedical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mofailure. List only one cause on each line. Oxycodone Intoxica Focal Bronchopneumo	ation and Hero	in Abuse,	Between Onset and Death			
xaminer	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
<u> </u>	Sequentially list conditions, If any, loading to immediate Due to (ur as a cunsequence of):						
miner	cause. Enter Underlying Cause (Disease or injury that initiated c. Due to (or as a consequence of):						
executed an and al - transit	West to resulting in death, cast						
~ 2 EE 7	■ MENDED 23a,27,28a-f per	me gy12 2-28-					
876C ifficate ag phys s the b	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	ath 3 Ectopic pregna	23d. Date of deliver	ery Day Year			
b. Box 6876C the death certificate by the attending physiched for use as the b	past 12 months? 4 Pregnant at time of death 5 Other (3) 9 Unknown	Specify)					
Fer Fer E	Part II. Other significant conditions contributing to death but not resulting in the underl	ying cause given in Part I.	23e. Did tobacco use contribute t				
of Vital Records, P.O. In Physician: The law requires that the After this certificate has been signed by the meral director, page 2 should be detached. To Be Completed by PP.			1 Yes 2 ✓ No 3 Pr				
Records, The law requires ficate has been sig page 2 should be Completed				autopsy findings available completion of cause of			
Reco			1 ✓ Yes 2 No 1 ✓				
of Vital Recipe Physician: The After this certificate neral director, page 11. To Be Cor	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check of Door Door Nursin	only one) g Home 5 Residence 6 Oth	ner.			
ion of Vitending Physicath. or: After this the funeral dir	1 Ves 2 No III Injury (Month, Day, Year)	28c. Injury at Work?	28d. Describe how injury occurred				
sion trendii death. rtor: A y the fi	Pending Investigation fd 12-11-10 fd 2:15pm		unknown	Pural Pouto Number City			
Division o spital or Attending tours after death. The filled in by the fure filled in by the fure Certification:	3 Suicide 6 X Could not be determined (Specify) Found at fireh		building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1601 Hanson Rd. Joppatowne, Maryland				
0 - 3 - 1	due to the cause(s) and manner as st	ated					
To the H within 24 To the F complete	at the time, date and place, and due to						
	29b. Signature and title of certifier	29c. License number O.C.M.E.	December 12,				
(2)	30. Name and address of person who completed cause of death (Item 23a)						
	Margarita Korell MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD	21201				
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Alice $20\overset{\text{Year}}{10}$ Brown December 7:10 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Min. 1 □ M 2 🗓 F DEC 18, Year 1952 Mary Land Director 215-60-1115 Usual Residence of Deceden or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1X Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2702 Classen Avenue, Apt. 2 21215 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 72 iled within 72 Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygier 7 is marked other to City Government Career Developer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Donald Johnson Alice Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy T. Hudson, daughter 2702 Classen Avenue, Apt. 1 Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 12/18/10 Baltimore, MD Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. Sterz 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 11000 Medical resulting in death) Due to (s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examin burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No ó Month Day Year Pregnant at time of death signed by the a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy yes 2 After this certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 1 Natural within 24 hours after death.

To the Funeral Director: At completed filled in by the fu death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 13, 2010 8:42p M Dorothy Nell Covington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 X 1272671927 Yrs. Texas Director 82 467-32-5311 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 ☐ Yes ŽŽ No Harford BelAir Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21015 USA 1308 N. Scottsdale Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11 Marital Status Black White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mineola Dabnev Curtis Black 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Scottsdale Dr., Bel Air. MD 21015 1308 N. (daughter) <u>Susan Covington</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/15/2010 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Company ^{22. Name and Address of Facility} Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Fracture disease or condition resulting in death) Medical Due to or as a consequence of): 2 WYCKS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION AND PROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of): Cause (Disease or linjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 X No Month Hospital or Attending Physician: The law requires that the death should be detached for Day 5 Other (specify) Pregnant at time of death g 🗍 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ fuille, hypiny ruis 10 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cercho vasular disces has autopsy page 2 performed?.

1 Yes 2 XNo 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ★Other (Specify) We 301 Cl 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, 2 (ar) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 ☐ Yes 2 😿 No injury 1 Natural 5 Pending Fell from whedchen UNK M NOVEMBER 24, LOID 2 Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ASCITED WAY FRILING 28f. Location (Street and Number of Fural Route Number City or Town, State) 410 F. McPhail Road, Bel Air, Maryland determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number (830) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles TOHSON MO 31. Date filed (Mo Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 4110P. Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death County of Death Examiner ltimo mD (al If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex (Month, Day, Funeral Days Min. 1 🗆 M 2 🗶 F Director Yrs. -1944 212-42-8409 66 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director X☐ Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1418 N. Decker Avenue Funeral 21213 S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 **X**No Maryland 21215-0036 Specify: Black 1 Tes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Various Jobs llth grade Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Counts Pauline Towson 19a. Informant's Name/Relationship (Type, Print) Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria A. Little- daughter 1418 N. Decker Avenue <u>Balto,MD 21213</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XXBurial 2 ☐ Cremation 3 ☐ Removal from State KIng 4 ☐ Donation 5 ☐ Other (Specify) 12-16-10 Randallstown, MD Mem Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 21202 1101 Ε. North Avenue Balto, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) ic cancer to live Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Law Increal Director: After this certificate has been signed by the attending physician and energi filled in by the funneral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live Birth 2 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Day Year 2 1 g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to dical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred injury ✓ Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the Within 2 To the F only one) 29b. Signatu and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year)

Registrar DHMH 17 Rev 7/2009

State

22

nd address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear Physician/ Gloria Crowder 7:08 A M 20 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Emeritus Senior Living 8. Date of Birth
June 28, Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 👿 F Months Year) 1938 Washington, D.C. 213-34-9876 **Director** Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at genee. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21209 USA 5729 Pimlico Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 x No Specify. If Yes, Give Specify: Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Rehab Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Georgian Mitchell Bernice Stancil Bea1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5803 Pimilco Rd., Baltimore, MD 21209 Ralph Ray (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Entombment Loudon Park Cemetery 12/18/10 |Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funer Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final cancer pancreatic Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or imjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has director, page 2 a autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified MSKaj aparneM.D 12/15/10 DUUS7465

State Registrar Baltimor, MD. 2120 9

2835 Smith AV -5-203

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N-S. RUJAPAKEEMD

31. Date filed (Month, Day, Year)

DEC 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For State Amend Item 25 per me, g910, 12/17/2010 dhb
Registrar Certificate of Death
Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 5: **Physician** BERNARD November DAVES 20 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins
5. Social Security Number 6. Bay view Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 **X**M 2□ F Director 218-56-0127 01-21--1952 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.

anit. If item 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, if a Madical Examina in that the motified at 1X Yes 2 No Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6112 CARDIFF AVENUE Funeral 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 **X**es 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ∐Yes 2 XNo Specify. Specify: BLACK 2 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) KROGERS GROCERY WAREHOUSEMAN 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **EDNA BRUCE** ပ JOHN DAVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).

1215 MADISON AVENUE BALTIMORE, MD 21217 APT 204 19a. Informant's Name/Relationship (Type. Print) RENE DAVIS/DAUGHTER Department of Health Important: If item 27 any Injury or other troonce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ≥ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/08/10 OwingsMills, MD On Site/ Garrison Fo. 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service License 1701-31 LAURENS STREET BALTIMORE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immiliate Cause (Final **Physician** hour Respiratory disease or condition resulting in death) /Medical Due to (or as a conseque re of): CATCAL APPROVED BY MEDICAL EVANIMEN Examiner Intracerebral edemo Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-fransit completely filled in by the funeral director, page 2 should be detached for use as the burlar-fransit Intracrania. Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, CERT IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 XHo 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 20, 2010 KDS-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 VA Avenue Baltimore MD 4940 Eastern MD J. Meren 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH G910 12/01/10 JH Amend Items 25tate, 28 Mary land Department of Herth rough Mental Hygiene 1 - For Amend Items 25,-... Registrar #20b, perFH, G910, 12/20/10, WS Certificate of Death Reg. No. 2. Date of Death 3. Time of Death **Physician** Month Day Year IQU: or 27,2010 Rhora NIOLIEML /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northwest Randa LP4TRI SILIMORE 0 If Under 1 Year | If Under 24 Hrs. 8. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 216.84.9004 1 □ M 2 🕱 F Yrs **Director** 07 1973 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Examination must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 15altimore 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Essex 4117 21207 USA Load Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 20CK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Alliance 12th grade redit Acct 1 year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lalph 4thay wasnington Davis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Attlay Williams Road Baltimure MD 21207 Mother 4117 Essex 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Woodlawn Cemetery 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/03/2010 Baitimone, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Valigno G Greene Filhoral Services 8728 Liberty Road Randallstown MO 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Fip I disease or condition resulting in death) **Physician** /Medical **Examiner** 60 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine the Hospital or Attending Physician; The law requires that the death certificate be executed 005 +0 MS #25 - Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Ye ar ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Division of Vital 1 ∐ Yes 2 **0** No 1 Tes after death.

Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No Certification: To 2 ER/Outpatient 3 DOA Inpatient Date of Injury 27. Manner of Death 28b. Time of 28d Describe how injury occurred Subject operator of a motor-28c. Injury at Work? 5 Pending investigation Vatural 2 Accident 06/16/2007 6:05 1 □Yes 2 XNo cycle collided with a car \mathbf{p} M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Byrai Route Number, City or Town, State) 2500 Block of Garrison Boulevard, Baltimore, 4 T Homicide within 24 hours at To the Funeral D completely filled it Roadway Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basic of examination analysis invatigation in the cause of examination and the cau Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 053250 Noven, Ser 27,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Worthwest Hospital Center : JUGWERTZ even 31. Date filed (Month, Day, Year)
DEC 0 1 2010 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene state Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ²9, 2010 F. Dawson November 6:50 P M James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Manor Care-Bethesda Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Hours March 2, 1922 Washington, D.C. Months 88 Yrs. Director 577-24-6950 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 ី No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ıral", or items 23a oı Examiner must be Funeral 500 King Farm Boulevard #201 20850 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 Divorced 4 Divorced WWII Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 72 alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Savings and Loan Savings/Loan Executive Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic events. ည Ellen Myers Joseph Thomas Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 King Farm Blvd. #201, Rockville, Maryland 20850 Yolanda D. Dawson / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 4, cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2010 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M0136023a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 5 Months Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hypertension Years attending physician and for use as the burial-tran Due to (or as a consequence of): CERTIFICATY Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death be detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Subdural Hematoma, Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an • Hospital or Attending Physician; The law 1 24 hours after death. • Funeral Director: After this certificate has b page 2 performed? Yes 2 X No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 **X** No 28d. Describe how injury occurred injury 1 Katural 2 X Accident 5 Pending Multiple falls November, 2010 Unknown M Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 28f. Location (Street and Number of Bural Boute Number, City or Town, State) 500 King Farm Boulevard, Rockville, MD 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certific 29d, Date signed (Month, Day, Year) 609 December 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

10+1

Registrar's Signature

Raman R. Tuli, M.D. 10810 Darnestown Road Suite 202, Gaithersburg, Maryland 20878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene me g910,12/17/2010dhb Reg. No.

Certificate of Death Reg. No. For State Registrar Reg. No 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2010 13:30 M Physician/ Davis Decembe reraldine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Seasono Hospice Rand a If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K Days Hours (Month, Day, Year Min. 5-40-53 **Director** Usual Residence of Decedent show 10b. County 10a, State death with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ISA 212 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: Completed 3 Widowed 4 □ Divorced Year or Dates It of Health and Mental Hygiene.

If item 27 is marked other than "natul or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) city schools istodian NIA 1214 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughler Holland erly Kimb 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Barial 2 ☐ Cremation 3 ☐ Removal from State 12-11-2010 ansdorme, mo. nr. 2100 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dalto. md. 21229 23a. Part 1. Enter the flisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory prest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracerebral hemorrhoge disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Aterosclerotic Cardiovascular Disease CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours after death.

To the Funeral Director After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1 No the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) 6 Other (Specify) examiner? Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) nstlyapathem.n 00057465 12/8/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MO-21209. N.S. Kujapakse Smith Day, Year,

State Registrar 31. Date filed (Month

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year William J. Evitts 8:19 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year | 9 / 26 / 1 9 4 2 9. Birthplace (State or Foreign Country)
11inois 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 68 Director 223-56-6738 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3601 Greenway Unit #610 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: "natural", 3 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumosta. Elementary/Seconday (0-12) College (1-4 or 5+) Professor Education 4+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Evitts Wilmeth A. Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Evitts (SPOUSE) 3601 Greenway Unit #610 Baltimore, MD 21218 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Cremetory 12/20/10 Baltimore, Maryland 22. Name and Address of FacilitySchimunek Funeral Home . Signature of Suner Service L Belair Road Nottingham, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) photopion Medical ue to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Pregnant a Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signompleted filled in by the funeral director, page 2 should to 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 1 🔲 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗌 Yes 2 🗌 No 1 X Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 2 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#16a, 19a, per FH, G910, 12/27/2010, wS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 30 PM DWARD EIL F De 2016 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE Avenue unda Age (In yrs. last birthday)
Yrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** 1**M**M 2□F Months Days Hours Min 217 - 13 50kg Usual Residence of Decedent Director the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notifled at 1 Tyres 2 No MD Director unda 4 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with tonent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or? USA 6854 21222 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼es 2 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Manager Elementary/Secondary (0-12) College (1-4or 5+) 12 KASINE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Edu Jae Ok Ellis-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) undalk MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City permit. Pages 1
Department of H
Important: If Itel 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cenekry 12-16-10 4 ☐ Donation 5 ☐ Other (Specify) Balhmere 22. Name and Address of Facility Bradky - ASK ton Functul 21. Signature of Funeral Sen PA, 2134 Willow Spring Read 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician lasmacytomo /Medical Due to (or as a con equence of) Examiner Lord Lompressio Jequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Caraio my opathy
Due to (or as a consequence of): To the Hospital or Attending Physiclan; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) ed by the a detached f 1 Yes 2 No 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 ☑ No 1∏ Yes Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) / 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signa 29d. Date signed (Month, Day, Year) 4-0063476 cause o' death (Item 23a) (Type, Print) erson who complete 4924 Campbell Blvd, Suite 200, Bathmore, MD 21236 31. Date filed (Month, Day, Year) 32/Registrar's Signaty State 2010 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland					Mental Hy	giene	0.1.0	10000
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	tificate	OI L	<i>Death</i>	2. Date of De	Reg. No.	U.H.U	3. Time of Death
	Physicia			Early						Month i 2	Day	Year 70//)	C20 M
	Medic Examin		4a. Facility Name (if not institution,				4b. City, To	wn, or	Location of Death		- ' `	ounty of Death	
1	-	٠.	Dove H	ause			0	Ue	2 min fe	stev		Carro	1)
	Funeral		5. Social Security Number	6. Sex 1XXM 2 ☐ F	e (In yrs. las		If Under 1 Months I		If Under 24 Hrs. Hours Min.	8. Date of Bir	th v. Year)	9. Birth	place (State or Foreign
	Director		578-56-5416	1282 3 VI 2 L. F	64	Yrs.				June 2	7, 194	46 Wasi	nington, D.C.
	nd how at	or	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation	-					10d. Inside City Limits
	laryla 3a-fs ified	Director	Maryland Cari	roll		Manche	ester						1 ☐ Yes 2XXNo
	or 2% e not	Dir	10e. Street and Number	-011		- Idileii	10f. Zip C	ode			10g. Çitizer	n of What Cou	ntry?
	with s 23a ust b	Funeral	3151 Pyramid Cir	rcle			2	2110)2			ited St Americ	
	death item ner m		11. Marital Status	12. Was Decedent E Armed Forces?	196				spanic Origin? (Spanic Angles)		14.	Race - Ameri Black, White,	
S	after Il", or xamil	d by	1 ☐ Never Married ※XX Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1XXYes 2 I If Yes, Give	No 196	- 1	☐ Yes 2	o/XX	Specify:		Spe		ack
9500-c	nours latura ical E	Completed		Year or Dates.	- 1	16a. Deced	ent's Usual (Occupa	ation		16b Kind	of Business In	
<u>ი</u>	יי א 72 ה ה: an "n Medi	mp		st grade completed) College (1-4 or 5	<u></u>	(Give k	rind of work of NOT use re	done d	luring most of work	ing	TOD: Pand	or Backness ii	laddiny
7	withii giene er th t, the		12th	College (1-4 of c	,,,	Packa	age Ha	ndl	.er		Unite	ed Parc	el Service
yland	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, La	ast)					18. Mother's Nam	ne (First, Middle,	Maiden Sur	mame)	
ya Ya	uld be I Men narke natic	-	Garney Early						Mable				
<u> </u>	2 sho th and 77 is r traun		19a. Informant's Name/Relationsh						and Number or Run			•	·
<u>ရ</u> ်	and Heal tem 2		Kierre Vinson (20a. Method of Disposition	, Daugnter)	20b. Pla	ace of Dispos	sition (Name	of	ircle, M	ancnest _{Date}		tion - City or T	
<u> </u>	age 1 ent of nt: If i y or o		1 ☐ Burial AXX Cremation 4 ☐ Donation 6 ☐ Other (S)	3 Removal from State	All ^{ce}	metery, crem Faiths	atory or other	e <i>r plac</i> la LO	rv De	c. 21, 010		*	:
baltimor	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Inmportant: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Fund Service/			& Char	DE L . Name and /	Addres	ss of Facility Ec				Maryland el, P.A.
ă	permi Depar Impor any ir		() Skyn OXMU	ing.		32	296 Ch	arm	il Drive	, Manch	ester,	Maryl	and 21102
			23 . Part 1. Enter the disease, or of sock, or heart failure. List or	complications that caused	the death.	Do not ente	r the mode o	of dying	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between
~P	hysician/		Imm diate Cause (Final disease or condition	Non	-S14	all.	cell 1	len	Canh				Onset and Death
<u>.</u>	Medical Examiner		resulting in death)	Due to (or as	a conseque			-					
	жанны	er	Sequentially list conditions,	b. Due to for so								_	
آ م	ed Isit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a conseque	erice otj:						- 13	
)	xecut	Еха	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):							
20	physician and the burial-transit	dical Examiner	•	d									
0 / 00	inicate ng phy as the	w I	IF FEMALE:										
Ď]	n cen tendir ir use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	of pregnan 2 🔲 Fetal	death 3			y		230	d. Date of deliv	
ממן	the at	Physician/M	1 Yes 2 No 9 Unknown	4 🗌 Pregnant a 9 🗍 Unknown	t time of de	eath 5	Other (spec	cify)				Month	Day Year
2	ed by detach	Ph	Part II. Other significant condition	ns contributing to death b	ut not resu	Iting in the ur	nderlying cau	use giv	ren in Part I.	23e. Did 1	obacco use	contribute to t	the cause of death?
ָר .	signe d be o	d by								1 🗆	Yes 2 🗆	No 3 ☐ Pro	bably 4 hnknown
ecords,	been shoul	lete								24a. Was	an 2	24b. Were auto	ppsy findings available
ָט ט	e has age 2	Completed								auto	ormed?	prior to co death? 1 \(\sum \text{Yes}	ompletion of cause of
E 6	an: Intificat	Be C	25. Was case referred to medical					26. Pla	ace of Death (Chec		2 40	1 L Yes	2 (1816
	ysica iis cer direct	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 E	R/Outpatien	t 3 🗆 DOA	Othe	er: 4 Nursing H	ome 5 🗌 Resi	dence 6	Other (Specif	n Dove 46000
5	ng PT fter th ineral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of inju (Month, Day		28b. Time of injury	28c	. Injury work	/ at	28d. Describe			
VISIOII OI	tendi leath lor: A the fu	ifice	2 Accident Investig	ation			М		Yes 2 No				
	or An after of Direction by	Certificate:	4 Homicide determi			ne, farm, stre	et, factory, c	office		28f. Location (City or To		lumber or Rura	d Route Number,
ב	spiral neral i filled		29a. Certifier 1 Certifying	Physician: To the best of	my knowle	dge, death o	ccured at the	e time,	, date and place, a	nd due to the ca	ause(s) and n	nanner as stat	ed.
-	To the bropping of Autonomy Priysican: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Medical		xaminer: On the basis of e Nurse Practioner: To the									
,	Vith To th		29b. Signature and title of certifier	10			29c, L	icense	number		29d. Date s	signed (Month,	Day, Year)
	- 1		* Kiku Ja	lice mi	2,8	nn		200	06459	7	12	1/Fi	110
	241		30. Name and address of person w	0			. 1	25.					
	Stat		31. Date filed (Month, Day, Year)	Rice MD		re .	1 3h	, 1	11) 20	157			
	રાવા Registra		31. Date filed (Month, Day, Year) DEC 20 2010	32. Regista	100	Vice							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 50 PM Fales Shirley J. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death FRANKLIN SQUARE Rosedale Baltimore Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign New York Jan 20 1935 1 M 2 TxF Months Hours Min. 216-32-0778 75 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director or 28a-f sh notified a MD Baltimore Essex 1 ☐ Yes 2 🛣 No 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be 21221 Funeral with 1 23a 465 Torner Road USA items ; death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black White etc. 1 e s s h 21215-0036 ō Ď 1 Never Married 2 Married hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural", 3 XWidowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lockheed Martin Secretery 12th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maude A. Miller William H. Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa R. Blondell/daughter Yew Road Baltimore MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Oak Lawn Cemetery 12/21/10 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licenses 22. Name and Address of Facility 300 Balto Mace Ave. of Essex 21221 Connelly Funeral Home Part 1/ Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease. Immediate Cause (Final Onset and Death Physician. Due to (or as a consequence of): hock disease or condition resulting in death) Medical Examiner embolism almonary Sequentially list conditions Examiner Que to for as a consequence of: cause. Enter Underlying Cause (Disease or iinjury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ breasT 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page 2 Be | 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 2 🗖 No ည 1 🗋 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending Investigation Accident within 24 hours after deat To the Funeral Director. completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 29d. Date signed (Month, Day, Year) D of person who completed cause of death (Item 23a) (Type, Print) FRANKLin Square DR Balto md 21237 20 9000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State arka Registrar

10-09623
Daelyn Faulkner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aelyn Faulkner		State - For State egistrar	e of Maryland / De <i>C</i>	epartment of F Certificate of D		Mental Hy		2010	40041
Physician	1	Daelyn Fa	ast)		-		Date of Death Month December	Day Voor	3. Time of Death 0530 hrs
Medical Examine		4a. Facility Name (if not institution, o		4b.	City, Town, or L	ocation of Death	December	4c. County of Death	
	ı	2309 Homewood Avenu			Baltimore				
Funeral Director			Sex 7. Age (In yr		f Under 1 Year Months Days	If Under 24Hrs. Hours Min.	7	(MM/DD/YYYY) 9. Birt 0,2009 Foreig Cou	hplace (State or n untry) MD
any		Jsual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Location					10d. Inside City Limits
	_	MD		Baltim	ore				1 XYes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		1	Of. Zip Code		10	g. Citizen of What Cour	ntry?
- 2 -		2309 Homewood	12. Was Decedent Ever in	in II S 13 Was F	2121	. 8 anic Origin? (Spe	ecify Yes or No-	USA 14. Race - Ameri	can Indian, Black,
eath wi	=	11. Marital Status 1 🗶 Never Married 2 🔲 Marri	A F	If Yes,		Mexican, Puerto		White, etc.	
after d) 전		ed If Yes, Give Year or Dates:	1 Y	es 2 No			specifyBlac	
hours natur Exam		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed College (1-4 or 5+)	d) 16a. Decedent's during most	Usual Occupation of working life.	on (Give kind of w DO NOT use retir	ork done ed)	16b. Kind of Business/I	ndustry
5-0036 led within 72 hou stygiene. other than "nati	Completed	none	Joine go (T. For C.)	n/a				n/a	
21215-0036 Muld be filed within 7 Mental Hygiene Hagine to event, the Medica		17. Father's Name (First, Middle, La			1	8.Mother's Name	(First, Middle, M Ghols		
2121 Muld be fi Mental marked c event,	lo Be	Darryl Faulki 19a. Informant's Name/Relationship	The state of the s	19b. Mailing A	ddress (Street	and Number or R	tural Route Num	ber, City or Town, State	, Zip C9de) 2 3 6
MD d 2 shoulth and I is numatic	<u>ا</u> ا	Mary Scatterf	-	other) 2	Dunsin	aneDr.	Apt.I	Nottingha	m, <u>MD</u>
ages I and 2 nt of Health nt: If item 2 other traum		20a. Method of Disposition 1 XBurial 2 Cremation	3 Removal from State	Ob. Place of Disposition crematory or other	place)		Date	20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	-1	4 Donation 5 Other Spec	ifs:	OulaneyVa					o,Co,MD
Baltimore permit. Pages 1 Department of F. Important: If injury or other	+	21. Si a three Funeral Service Li	Puser	Cal	vin B.	Scrug	gs Fun	eral Home	21213
Physician	4	23a. Part I. Enter the disease, or co failure. List only one cause or		eath. Do not enter the	mode of dying,	such as cardiac or	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
miner	i	Immediate Cause (Final disease	a. Smoke Inhalation						Death
	1	or condition resulting in death)	Due to (or as a consequent b.	nce or):					
	<u>ĕ</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequen	nce of):					
ansit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	nce of):	_	_			
50, te be executed ysician and burial - transit	ledical	UNPENDED	AMENDED			_			
ficate be g physici the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		death 3	Ectopic pregna	ancv	23d. Date of deliver Month	y Day Year
Box 6876 e death certificat the attending phy ed for use as the	Sign	past 12 months?	4 Pregnant at time		r (Specify)				
. Bo he deat y the at	Physician/N	1 Yes 2 ✓ No 9 Unknown Part II. Other significant condition	a CHKIOMII	not resulting in the unc	derlying cause g	iven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
P.O.		, a.t. iii otiloi o.g.					1 Yes	2 No 3 Pro	bably 4 🗹 Unknown
rds, require been si hould t	Completed by						24a. Was autop		utopsy findings available completion of cause of
eco he law ate has	E O				-			rmed? death? 2 ✓ No 1 Y	es 2 No
tal R	BeC	25. Was case referred to medical examiner?	Hospital: 4 Longtiont			of Death (Check		Residence 6 🗸 Othe	
Physic Physic er this eral dir	의	1 ✓ Yes 2 No 27. Manner of Death	inpatient 2	2 ER/Outpatient 28b. Time of Inju		y at Work?	28d. Describe	how injury occurred	er. Scene
sion o .ttending death. ctor: Aft	흲	1 Natural 5 Pendir		0430 hrs	1 1	′es 2 ✓ No	Victim of ho	use fire	
ivision Att	Certification:	2 Accident Investi 3 Suicide 6 Could	not be 28e. Place of Injury -	- At home, farm, street,	factory, office b	uilding, etc.	or Town, S	State)	ural Route Number, City
Spital hours a prilled y filled	3	4 Homicide determ	(Specify Oligic			ate and place and	!	ood Avenue , Baltime	
Division of Vital Records, P.O. Box 6876 within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only one) 2 Medical Exam	sician: To the best of my kno iner: On the basis of examinat and manner stated.	owieage, aeath occurre tion and/or investigation	n, in my opinion	, death occurred	at the time, date	and place, and due to t	he cause(s)
To vit	Me	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signed (Me	
		hig his	, WD		O.C.I	M.E.		December 14, 2	2010 ————————
\		30. Name and address of person was Ling Li, MD Assistan	ho completed cause of death t Medical Examiner	(Item 23a) 111 Penn Street	Baltimore.	MD 21201			
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature	,				
Regist		DEC 2 0 2010	Deserra B.	barker					

10-09627 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Darryon Faulkner 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0530 hrs **Medical Examiner** Faulkner December 14, 2010 Darryon 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2309 Homewood Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5 Social Security Number **Funeral** 7. Age (In yrs. last birthday) Country) Days Hours Director June 15,200 MD 2___F 1 X M 214 79 4884 3 Yrs Usual Residence of Decedent 10d. Inside City Limits any 10b. County 10c. City, Town or Location e notified at once, 1 XYes 2 No MD Baltimore Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Impurtant: If item 27 is marked rother than "natural", or items 23a nr 28a-f sho 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 2309 Homewood Ave. 21218 USA ā Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Inther than "natural", or items the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No Black 1 Yes 2 X No specify: 4 Divorced Give Year ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry eted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Comple n/a n/a n/a 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Darryl Faulkner Tiara Gholston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Satterfield (grandmother) 2 Dunsinane Dr. Apt. I Nottingham, MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State crematory or other place) DulaneyValley Cembec.22,201 Balto, Co, MD 4 Donation 5 Other Specify. 21. Supplied of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto.Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Balto, Md Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Smoke Inhalation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical 24a per me g913 3-11-11 vt attending physician a or use as the burial -UNPENDED X AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been ector, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed page Tes 2 X No 1 🗸 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this (Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Dec 14, 2010 Victim of house fire Natural 5 Pendina 24 hours after death. d in by the f 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 2309 Homewood Avenue, Baltimore, MD determined (Specify) Single Family Home Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 14, 2010 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registrar

31. Date filed (Month, Day, Year)

arks

Registrar's Signature

1- For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2010 /Sada /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** N/A The Johns Hopkins Hospital | Honder 1 Year | Honder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | Feb. 16, 1952 Birthplace (State or Foreign Country)

Jamaica, WI 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🕶 F 58 Yrs. 213-61-1703 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ▼Yes 2 □ No Director MD N/A Baltimore 10f. Zip-Code 10g. Citizen of What Country? 10e Street and Number USA 21213 3855 Elmley Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Renaissance Hotel 12th Grade Housekeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ivy Smith Victor Eastwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9542 Wesland Circle Randallstown, Maryland 21133 Karen Taylor - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemeterv 12/11/2010 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, Maryland 21206 21. Signature of Funeral Service Licenses Narros Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detacted Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 No 2 No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1X Yes Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - ER/Outpatient 3 🗆 DQA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manney of Death Certification: To the Hospital or Attending 1 Natural 5 Pending Injury 1 🗀 Yes 2 🗌 No investigation death. eral Director; Al filled in by the fu 2 Accident Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Mon i State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? for State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 27M Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Saltimor onter If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign n *yr*s. last birthday) 61 yrs. If Under 1 Year **Funeral** 1 🔀 M 2 🗆 F Days Min (Month, Day, 216-54-6115 Marvl Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Completed by Funeral Director be notified 1 Yes 2 X No Columbia Howard Md. 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 U.S.A. 21044 23a 10586 Jason Court 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1- Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done of life, DO NOT use retired) during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) Aspen Systems Purchasing Agent Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Regina Margaret Nowicki William Frank Fabiszak, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6723 Bessemer Avenue Baltimore, Md. Regina M. Fabiszak/Mother 20c. Location - City or Town, State December 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 20,2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematory Bayview 22. Name and Address of Facili Kaczorowski Funeral Home, PA Signature of Funeral Service Licer Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on so he line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b, Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 🗌 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 8b. Time of Certificate: Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 5 D Pending Natural 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and addressor person who completed cause of death (Item 23a) (T Brown 32. Registrar's Signature 31. Date filed (Month. State Registrar

DHMH 17 Rev 7/2009

			amend #1 Per	РНУ G910 12/20/10 tate of Maryland / Depa	THE ARCHING PROPERTY OF THE ARCHING THE AR	Mental Hygie	ne	
		1	State Registrar	Сег	rtificate of Death	Reg	. No.2010	40045
П	Physicia Medic		1. Decedent's Name (First, Middle, Last)	Alonza Graha	m.	2. Date of Death Month	12010 Year	3. Time of Death
	Examin	_	a. Facility Name (if not institution, give stree		4b. City, Town, or Location of Deal	h	4c. County of Death	
			3433 Flannery La 5. Social Security Number 6. Sex	ne 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs	8. Date of Birth	9 Birth	place (State or Foreign
	Funeral Director		241-48-4438 1 X M		Months Days Hours Min			
	land show dat	l. 1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	ne Maryland or 28a-f shov notified at	ecto	MD NA	Balti				1 XYes 2 No
	the N a or 28	Funeral Director	10e. Street and Number		10f. Zip Code	10g	g. Citizen of What Cou	ntry?
	s after death with th ral", or items 23a o Examiner must be	nera	3433 Flannery La		21207		U.S.A.	
	or iter	by Fu	- Maria Status	Was Decedent Ever in U.S. Armed Forces? I ☐ Yes 2 ☒No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecity Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	etc.
93	2 hours afte "natural", edical Exan	ed b		f Yes, Give Year or Dates.	1 ☐ Yes 2 🛛 No Specify:		Specify: B	lack
Maryland 21215-0036	hould be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f sho umatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educat (Specify only highest grade co	impleted) (Give	dent's Usual Occupation kind of work done during most of wo O NOT use retired)	rking 16	b. Kind of Business In	dustry
712	vithin jene.	Con	77.7	College (1-4 or 5+)	Laborer	l _v	arious J	obs
pu	filed within all Hygiene. dother than event, the News	Be	17. Father's Name (First, Middle, Last)		1175-131-3111-15-5-1	me (First, Middle, Maid		
ylai	Menta narked	ပ	Walter Graham			Bowie		
Mai	S L	- 8	19a. Informant's Name/Relationship (Type, F Glendora Graham-		ng Address (Street and Number or Ri 3 Flannery Lan			
	ye 1 and 2 s t of Health If item 27 or other tra	1	20a. Method of Disposition	20b. Place of Dispo			c. Location - City or T	
<u>ii</u>	Page ment o ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ Rem		morial Park 12	/17/2010	Woodlaw	n, Md
Baltimore,	permit. Page Department of Important: If any injury or once.	1	21. Sign ure of Funeral Service Licensee	Fuelli Mi	2. Name, and Address of Facility arch F/H West 300 Wabash Ave	, Baltim	ore, Md	21215
-	Physician/		23a. Part 1. Enter the disease, or complicati spock, or heart failure. List only one ca immediate Cause (Final	ons that caused the death. Do not ent				Approximate Interval Between Onset and Death
Ŧ	Medical Examiner		disease or condition resulting in death)	Due to (or as a contequence of):	spear sy	CHOULD		
	ed sit	Examiner	Sequentially list conditions, if any, leaving to firm ediate cause. Enter Underlying Cause (Disease or linjury	Cue to (or as a nonsequence of):				
_	be executed sician and burial-transit	cal Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):				
68760	icate t physics the b		d					
Box 68	e death certificate be the attending physiched for use as the beat the the death.	Completed by Physician/Med	in the past 12 months?	f yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ ☐ Pregnant at time of death 5 ☐ ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	very Day Year
s, P.O.	requires that the des been signed by the s should be detached t	d by Pr	Part II. Other significant conditions contrib	uting to death but not resulting in the u	underlying cause given in Part I.		cco use contribute to t	he cause of death?
ord	requires been sig should b	lete				24a. Was an	24b. Were auto	ppsy findings available
3ec	hysician: The law nis certificate has b I director, page 2 s	omo				autopsy performe 1 Yes 2	d? death?	empletion of cause of
ta	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?	ital	26. Place of Death (Che			
ί	Attending Physician: The sr death. ector: After this certificate by the funeral director, page	욘	1 ∐ Yes 2 LØ 1940	1 Inpatient 2 ER/Outpatient 2 Bb. Time of		Home 5 Residence 28d. Describe how i		y)
o uc	nding Physath. :: After this e funeral di	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury	work? M 1 ☐ Yes 2 ☐ No	Zod. Describe now	ingary occurred	
Division of Vital Records,	l or Atte after dea Director	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 Medical Examiner:	: To the best of my knowledge, death On the basis of examination and/or invest actioner: To the best of my knowledge,	stigation, in my opinion, death occurred	at the time, date and p	place, and due to the ca	ause(s) and manner stated.
	To the within To the compl	2	only one) 3 LJ Certifying Nurse Pro 29b. Signature and title of certifier	The bost of the knowledge,	29c. License number		I. Date signed (Month,	
			• ()	Do.	14646		12/11/20	0
2			30. Name and address of person who comp	etedicause of death (Item 23a) (Type, I	ractoun Blo	13,.ba	desby	MD21784
	Sta Registra		31. Date filed (Month, Day, ear)	32. Registrar's Signature	0		0	

DHMH 17 Rev 7/2009

10-09625 Tiara Gholston Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 46 amend #1State of Maryland / Department of Health and Mental Hygiene

		l- For State Registrar			Certi	ificate of	Death			Reg. No	D.	
Physicia	n/	Decedent's Name (Fi	rst, Middle,Last)						2. Date Mont	of Death th Day	Year	3. Time of Death
Medical Examin	er	Tiara		Ghols	ton				Dece	ember 14,	2010	0530 hrs
		4a. Facility Name (if not 2309 Homewood	institution, give	street and num	nber)	4	o. City, Town, or Baltimore	Location of De	eath		4c. County of De	ath
Funeral Director		5. Social Security Numb	120	// 2∑F	7. Age (In yrs. Ias 26	t birthday)	If Under 1 Year Months Days		Min.	te of Birth(Mr	For	Birthplace (State or eign Country) MD
	H	Usual Residence of Dec		" 26.		110.			IDE	C.20,	1903	TID
any			County			own or Location			_			10d. Inside City Limits
Ĕ .,	ō.	MD			Bal	timor			·	140- 0	itizen of What C	1 Yes 2 No
the Mary	Director	10e. Street and Number 2309 Ho		Ave.			10f. Zip Code 2121	8			JSA	ound y?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married	2 Married 4 Divorced	Armed For	dent Ever in U.S. ces?	If Ye	Decedent of His s, specify Cuban Yes 2 No	, Mexican, Pu			14. Race - Am White, etc	
ours afte	ρ Σ	3 Widowed 4		or Dates: v highest grade		16a. Decedent	s Usual Occupat st of working life	ion (Give kind		ne 16b	. Kind of Busines	
D36 thin 72 h te. than "n	Completed	Elementary/Seconda	ry (0-12)	College (1-		· ·	udent		,		School	
5-00 ed wi lygier other	ोंड	17. Father's Name (Firs						18.Mother's Na	,		•	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medical	8	Dale Gh								erfie		
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	욘	19a. Informant's Name/ Mary Sat	Relationship (Typ terfie:	pe, Print) 1d (mo	other)	19b. Meiling 2 Du	Adresante ninane	ot and Number Dr.Ap	or Rural Ro	Notti		MD 21236
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 Injury or other fraum	Ī	20a. Method of Disposit		Removal fro	m State cre	ematory or oth	ion (Name of cerer er place) Valley	D€	ec.22	,20L0		
Itim iit. Pay urtment ortant ry or o	ŀ	4 Donation 5 21. S ture of Funera		ee ·	1541	2 <u>2</u> . Na	ame and Address	of Facility	1000		Balto	.Co,MD
Balti permit. Departm Importu injury	- L	0		- 1	کسی	Ca	lvin B	. Scru	iggs	Funer	al Hom	e 21213
Physician	寸	23a. Part I. Enter the difailure. List only o	sease, or complic	cations that ca	used the death, [Do not enter th	e mode of dying,	such as cardi	ac or respira	atory arrest, s	hock, or heart	Approximate Interval Between Onset and
!Wedical !xaminer		Immediate Cause (Fina or condition resulting in	l disease a. Ir	halation of	Smoke and							Death
	إ	Sequentially list conditi		uo to (or no n	consequence of):							
_	Examiner	if any, leading to immed cause. Enter Underlyin (Disease or injury that i	ng Cause		consequence of):							
executed in and II - transit		events resulting in deat	n) Last d									
	Medical	UNPENDED		AMENDED								
18760, rtificate be ing physici as the burn		IF FEMALE: 23b. Was decedent preg past 12 months?	nant in the	1 Live bir		2 Fet	al death 3	Ectopic pre	egnancy	2	23d. Date of delive Month	very Day Year
Box 68' e death certifi the attending ted for use as	Physician/	1 Yes 2 No 9	✓ Unknown	4 Pregna	int at time of deaf wn	th 5 Oth	er (Specify)					
that the ned by the detached	면 면	Part II. Other significa	nt conditions	contributing to	death but not res	sulting in the u	nderlying cause (given in Part I.				to the cause of death? Probably 4 Unknown
ds, leaduires							-		24	a. Was an		autopsy findings available
ecor ne law ra te has b ge 2 shd	Completed					_			- 1	autopsy performed Yes 2		
L T	ပ္မ	25. Was case referred t	o medical				26.Place	of Death (Che	eck only one	∋)	,	
/ita	Ď	examiner?	No Ho	spital: 1 Ir	patient 2 E	R/Outpatient	3 DOA	Other ₄ No	ursing Home	5 Resi	dence 6 🗸 🔾	her: Scene
n of viding Physh	۲	27. Manner of Death 1 Natural 5		28a. Date of (Month) Dec 14,	of Injury Day Year) 2010	28b. Time of Ir 0430 hrs	· ·	ry at Work? Yes 2 ✔ No	- ISuiad	escribe how i t was in h	injury occurred ouse fire	
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	Certification:	2 Accident 3 Suicide 6	Investigation Could not be	e 28e. Place	of Injury - At hor	ne, farm, stree	t, factory, office t	ouilding, etc.			t and Number or	Rural Route Number, City
Hospital 24 hours 2: Funeral etely filled		4 Homicide 29a. Certifier 1 Cer	determined tifying Physicia	n: To the best	of my knowledge	e, death occurr	ed at the time, d	ate and place,	and due to	the cause(s)	and manner as s	stated.
To the within 2 To the complet	Medical	one) 2 Med 29b. Signature and title		On the basis o and manner st	f examination and ated.	d/or investigati	on, in my opinior 29c. Licens		red at the tin			o the cause(s) Month, Day, Year)
		//	M		7	mi	O.C.	M.E.		De	ecember 14,	2010
<u>`</u>	ļ	30. Name and address Russell Alexan		ssistant M	edical Exami	iner 111	Penn Street,	Baltimore	, MD 212	01		
Sta Regist		31. Date NedaMônth C	M Pear) Den	32. Re	gistrar's Sronatic	El .			-	OGME		
5(:Ja) (Si	- 14		4		_					OUTVIL.		

	68	F	5	1	1	0	1	-
,		4	0	3.	1 1	11	L	1
ne .	U	É	1		Same?	\cup	-7	- /

		1- For State Registrar	,	Certificate of	of Death		, ,	Reg. No.	0 1 0	
Physici	an/	Decedent's Name (First, Middle	e,Last)				Date of De Month		Year	3. Time of Death
Medical Exami	ner		rick Gaith	er	45 City Taylor			er 17, 2010	nty of Death	1955 hrs
		4a. Facility Name (if not institution 11609 Legore Bridge F	<u> </u>		4b. City, Town, Woodsboi		or Death	Frede	-	
Funeral		5. Social Security Number	6. Sex 7. Age (I	n yrs. last birthday)	If Under 1 Ye			Birth(MM/DD/Y		thplace (State or
Director		213-94-2885	1 M 2 F	35 Y		ys Hours	Mar.	18, 197	75 Foreig	untryMaryland
		Usual Residence of Decedent								
м апу		10a. State 10b. County	10	c. City, Town or Loca	ation					10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show d at once.	ţō	4	erick		Woodsbo			40- 0%	140	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e, Street and Number			10f. Zip Code			10g. Citizen of		
ith the 23a o notifi	밀	10619 Woodsbor	O Pike 12. Was Decedent Eve	or in 11 C 1 12 1A	las Docadant of h	2179	gin? (Specify Yes or N	lo- 14 P	U.S	A. can Indian, Black,
ath w items	Funeral	1 Never Married 2 X Ma	arried Armed Forces?	if			, Puerto Rican, etc.)		hite, etc.	carringian, black,
		3 Widowed 4 Divo	1 Yes 2 X	No 1	Yes 2X	lo specify:		Speci	fy: Wh	nite
5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	d by	15. Decedent's Education (Spec	ify only highest grade comple		ent's Usual Occup		kind of work done	16b. Kind of		
6 172 h sn "n cal E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during i	most of working if	ie. DO NOT	use retired)	stone	•	
withir rer th	E C	12 17. Father's Name (First, Middle,			quarry		er 's Name (First, Middle	_		oducts
15- filed al Hyg ed oth	BeC	Gary L. Gai	,			16.Motrier	Carolyn		me)	
21215-0036 ould be filed within 7 Mental Hygiene. • marked other than ic event, the Medical	To B	19a. Informant's Name/Relationsh		19b. Mailii	ng Address (Str	eet and Num	nber or Rural Route No		own, State	, Zip Code)
○ 월 전 # T	П	Mary Gaither/ w	ife	10619	9 Woodsb	oro Pi	ike Woo	odsboro	, MD	21798
ore, MEss 1 and 2 sof Health an If item 27 her trauman		20a. Method of Disposition	2 Daniel franc 04-4-	20b. Place of Dispo		emetery,	Date	20c. Location	on - City or	Town, State
Pages ent of int: In		1 Burial 2 Cremation 4 Donation 5 Other Sp		Linganore	' '	rv	12/22/2010	Unio	nvill	e, MD
Baltimore, permit. Pages I a Department of He Important: If ite injury or other to		21. Signature of Funeral Service		/ 22.	Name and Addre	ss of Facility	Hartzler 1	Funeral	Home	
0 84 8 3), P	Catharise (. Harze		1802 Lib			rtytown		
Physician IV edital		23a. Part I. Enter the disease, or a failure. List only one cause of		death. Do not enter	the mode of dyin	g, such as c	ardiac or respiratory a	rrest, shock, or	heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Compressional As Due to (or as a consequ							Death
•			b.	ence or).						
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequent	ence of):						
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ence of):	_	_				
cuted nd transit			d							
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be excouted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED	AMENDED							
760, ficate be g physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		Satel death 3	Ectopic	programm	23d. Date Month	e of delivery) Day Year
Box 687 death certificate attending and for use as t	ciar	past 12 months?	1 Live birth 4 Pregnant at time	4	etal death 3 hther (Specify)	Letopic	. pregnancy	Wient		rea rea
BO)	Physician/		nown g Unknown							
ires that the signed by I be detached	by P	Part II. Other significant condition	ons contributing to death but	ut not resulting in the	underlying cause	given in Pa				the cause of death?
S, F puires in sign							24a. Wa:			topsy findings available
aw rec	B						auto	opsy formed?		ompletion of cause of
Records, The law requir fificate has been s	Completed						1 ✓ Yes	2 No	1 ✓ Ye	s 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Outpatier			(Check only one) Nursing Home 5	Residence (C A Othor	Cana
of Vital ling Physician After this certi funeral director	٦.	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of		jury at Work		how injury occ	(<u>*</u>	. Ocene
ath.	틾	1 Natural 5 Pendi	ing Dec 17, 2010	1955 hrs	1 🗸	Yes 2	No Subject en	trapped in s	tone cru	sher
Division tal or Attendir rs after death. al Director: A	fica		tigation 28e. Place of Injury	- At home, farm, stre	eet, factory, office	building, et			mber or Ru	ral Route Number, City
Dital of Div	Certification:		(Specify) Indus	trial Area			or Town, 11609 Leqoi	re Bridge Roa	d, Woods	boro, MD
Division To the Rospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		(Ondon only)	ysician: To the best of my kr							
To th withir compl	Medical	2 🛡	niner: On the basis of examina and manner stated.	ation and/or investig			curred at the time, dat			
	2	29b. Signature and title of certifier	1.10	-)		.M.E.		Decemb	-	nth, Day, Year)
		oun	14/	, M)						
		30. Name and address of person values and Ali, M.D. A	who completed cause of deat Assistant Medical Exan		nn Street, Ba	ltimore, N	MD 21201			
St	ate	31. Date filed (Month, Day, Year)	32 Registrar's							
Regist	trar	DEC 2 0 20	10 /2.ma	A. Jan	Kel					
DHMH 17 Rev 1/2	001			ORIGINA	AL			OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03 VAM RBARA 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Millersville</u> Anne Arundel Jumpers Hole Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, You Sept 21, Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1942 1 🗆 M 2 🗷 F Maryland **Director** 68 Yrs. 220-76-2537 Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director : If item 27 is marked other than "natural", or items 23a or 28a-fs or other traumatic event, the Medical Examiner must be notified 1 Yes 2X No Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21108 8240 Jumpers Hole Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'ampriatury or other traumatic event, the Meone. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A 0 Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Jacob Hutzler Laura Mae Randle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Hutzler, Brother 1348 Hollow Glen Court Curtis Bay, Maryland 21226 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/20/10 Baltimore, Maryland Crematory Inc Signature of Funeral Service Lieunsee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caus, if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each life. Interval Between Immediate Cause (Final Physician/ PIRATION disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: MEN To the Hospital or Attending Physlcian: The law requires that the death certificate be executed RIH resulting in death) Last Due to (or as a consequence of by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 \square Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	State of Maryland	•	tment of H		,	20	10	Lanis
			Registrar 1. Decedent's Name (First, Middle, Last)		Ceru	ilcate of D	catii	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia Medic		S	onia A. Hen:	son			Month 1 7_	Day 7	Year	4:10 PM
	Examin		4a. Facility Name (if not institution, give street	et and number)	4	4b. City, Town, or I	ocation of Death		4c. County	of Death	
. *			Union Memorial			Balti			na		
	Funeral Director		218-42-7572	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs, Hours Min.	8. Date of Birt 10-20	h -1944	9. Birthi Coun	place (State or Foreign htry) MD
	nd now at	r	Usual Residence of Decedent 10a, State 10b. County	10c. City, To	own or Local	tion			····	Ī	10d. Inside City Limits
	arylar a-fsl	Director			imore						1 🔀 Yes 2 🗆 No
	or 28 e not	Dir	MD na 10e. Street and Number	Daic	INOLE	10f, Zip Code		T	10g. Citizen of V	Vhat Cour	
	s 23a ust b	Funeral	1050 E. 33rd St	reet		2121	3		USA		
30	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 12. 1 ☐ Never Married 2 ☐ Married 3€€Widowed 4 ☐ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏿 No If Yes, Give	If Y	s Decedent of His es, specify Cuban Yes 2 X No	, Mexican, Puerto	cify Yes or No- Rican, etc.)		k, White,	ean Indian, etc. Lack
ş	nours natura ical E	ete	15. Decedent's Educa		6a. Deceder	nt's Usual Occupat	ion		16b. Kind of Bu	ısiness İn	dustry no
9500-61212	vithin 72 hiene. ir than "r the Medi	Completed	(Specify only highest grade of Elementary/Seconday (0-12) 12th grade	completed) College (1-4 or 5+)	(Give kin	d of work done du NOT use retired)	ring most or worki	^{ng} na	705. 14114 01 50		oustry na
ana !	be filed v ental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Hercules Willia	ms			18. Mother's Name			·)	
Maryland	2 should Ith and Me 27 is mar traumati		19a. Informant's Name/Relationship (Type, Candice Snowden	Print) Grand 1 - Daughter		Address (Street ar			r, City or Town, S		
baltimore,	age 1 and ent of Heal rt: If item ; y or other		20a. Method of Disposition 1 🛣 Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place	e of Disposit	ion (Name of tory or other place Cernete	1 1	Date	20c. Location -	-	own, State
Baltir	permit. Page 1 Department of Important: If is any injury or conce.		21. Signature of Funeral Service Lizen	<u></u>	22. 1	Name and Address	of Facility	March	East F	/H	21202
			23a. Part 1. Enter the disease, or complication	tions that caused the death. De						1	Approximate
Ц	mysician/ Medical		shock, or feart failure. List only one ca Immediate Cause (Final disease or condition resulting in death)	Brain		empation	2				Interval Between Onset and Death
	Examiner	-i-	Sequentially list conditions b.	Due to (or as a consequence lutra) Due to (or as a consequence	cereb	ral He.	norha	re		_	36 40
Ī	cuted ind transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	4.1	,	ive E	mergen	cy			36 hrs
00	ite be exe hysician a he burial-	edical E	resulting in death) Last	Un co	nt011	ive E ed Hyp	vertensio	7			2445
20 X 02 /	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	in the past 12 months?	If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Dat Mo	te of deliventh	ery Day Year
ў. О	es that the	by	Part II. Other significant conditions contril	outing to death but not resultin	ng in the unc	lerlying cause give	n in Part I.				he cause of death?
SDJ	require been s should	leted				_		24a. Was			psy findings available
VITAI Records,	: The law cate has	Completed						autop perfo 1 Yes	rmed?		mpletion of cause of
Ĭā	sician certifi irector	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hos	oital:		Other	ce of Death (Check				
n of v	ding Physh.	cate: To	27. Manner of Death 1 Natural 5 Pending	1 ☑ Inpatient 2 ☐ ER/ 28a. Date of injury (Month, Day, Year) 28b	Outpatient o. Time of injury	28c. Injury work?	4 □ Nursing Ho		lence 6 Othe ow injury occurre		/)
DIVISION OF	I or Atten after deat Director: I in by the	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At home, building, etc. (Specify)	farm, street			28f. Location (S City or Tow	treet and Numbern, State)	er or Rurai	l Route Number,
ר	Hospita 24 hours Funeral	Medical	(Check 2 ☐ Medical Examiner:	n: To the best of my knowledg On the basis of examination and actioner: To the best of my know	d/or investiga	ation, in my opinion	, death occurred at	the time, date a	nd place, and due	to the ca	use(s) and manner stated.
	To the within To the Comple	2	29b. Signature and title of certifier	• • • • • • • • • • • • • • • • • • • •		29c. License	number		29d. Date signed	(Month,	Day, Year)
) Jan 14	=> MP		AT 2	438946	-A7	12/11	12	010
			30. Name and address of person who comp	leted cause of death (Item 23a Union Muma	a) (Type, Prir	nt)					,
			Leanne Foster	Union Mumo	rol	Hospital	201 E. L	niversia	4 Phin	2 Bal	HMOR, MD 2121
	Stat Registra		31. Date filed (Month, Day, Year) DEC 2 0 2010	32. Registrar's Signature	aris						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G910, 12/20/2010, WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death December 16, Physician/ INPS CHARD 10:02 A.M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice **Baltimore** Towson 5. Social Security Number Sex XX M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Funeral 9. Birthplace (State or Foreign Year) 19<u>32</u> Months Days Hours Min. Country) Maryland 78 **Director** 220-26-9871 Usual Residence of Decedent 10a State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified 1 Yes XX No Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g Citizen of What Country?
United States Funeral 128 Hawthorne Avenue 21208 of America 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2XX Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 9th Equipment Operator State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H thent of Health and Ments trant: If item 27 is marked jury or other traumatic e should be Curtis B. Haines Gladys Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma F. Haines (Wife) 128 Hawthorne Avenue, Pikesville, MD 21208 Baltimore, Date 21, 20b. Place of Disposition (Name of Warehotsy, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Wars Chapel Cemetery 2010 Holbrook, Maryland Single of Fundamental Elicense 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sk, or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Onset and Doth Enysician/ ONCESTIVE HEART disease or condition **▶** Medical resulting in death) Due to (or as a consequence of) Examiner ITICAI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by HRONIC LYMPHOCYTIC LEUKEMIA Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 🗌 NO Yes 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 4 Nursing Home 5 Residence 6 Other (Specify HOSPICC Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 I Tatural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif d address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 687600 P.O. Division of Vital Records,

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of

31. Date filed (Month, Day,

death (Item 23a) (Type, Print)

60

32. Registrar's Signature

1)30433

Ballingre Ma 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1 Reg. PHY 6910d 12/28/100 III Health and Mental Hydiene

		-	For State Of Maryl		rificate of Death	and Mentan	Reg. No.	nin	1.0052
Ħ	Physicia	n/	1. Decedent's Name (First, Middle, Last)	YA St	ephen Hirka	2. Date of	Death iber I6	2ďľo	3. Time of Death 7:00a M
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)	<u> </u>	4b. City, Town, or Location		4c. Cd	ounty of Death	7.004
e e e e	Funeral		15620 Bushy Park Road 5. Social Security Number 6. Sex 7. Age (In y	yrs. last birthday)		r 24 Hrs. 8. Date of Month,	Birth	g. Birthp	place (State or Foreign
	Director		195-24-3415	Yrs.	Months Days Hours	Nov]	Day, Year) 9 193	3 Coun	PA
	aryland a-f shov fied at	ctor	10a. State 10b. County 10c MD Howard	c. City, Town or Loca Woodbi				1	l0d, Inside City Limits 1 ☐ Yes 2 1 No
	n the Ma a or 28a be notii	al Dire	10e. Street and Number		10f. Zip Code 21797		10g. Citize	n of What Cour	ntry?
	eath wit tems 23 er must	Funeral Director	15620 Bushy Park Road 11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13. W	/as Decedent of Hispanic Or Yes, specify Cuban, Mexica	rigin? (Specify Yes or N		. Race - Americ	
036	12 should be filed within 72 hours after death with the Maryland lith and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No K 1 ☐ Yes 2 ☐ No K 1 ☐ Yes Group Year or Dates.	Corea	Yes 2 No Specify		Sp	pecify: whit	
15-0	72 hour in "natu Medical	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give ki	ent's Usual Occupation ind of work done during mo DNOT use retired)	st of working	1	of Business Inc	
1212	d within lygiene. ther tha nt, the I	Be Col	Elementary/Seconday (0-12) College (1-4 or 5+) 12 17. Father's Name (First, Middle, Last)	engin	eering manage	er her's Name (First, Midd		ommunic	ations
yland	d be file Mental H arked o atic eve	To E	Michael Hirka		Mai	ria Andres			
Man	12 shoul		19a. Informant's Name/Relationship (Type, Print) Dorothy M. Hirka (spouse)	19b. Mailing 15620	g Address (Street and Numb Bushy Park I	ber or Rural Route Nur Rd., Woodb:	nber, City or To Lne,MD	wn, State, Zip (21797	Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cob. Place of Dispos cemetery, crem All Count	sition (Name of latory or other place) y Cremation	Date 12-19-10		ation - City or To ${ m vil}1e$,	·
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee		Name and Address of Faci				Chape1
	Pnysician/ Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequent ally list conditions, the conditions are consequent ally list conditions, the conditions are consequent ally list conditions.	nsequence of):	r the mode of dying, such a				Approximate Interval Between Conset and Death
092	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conduct of the conduct of						
. Box 687	ne death certific / the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23	8d. Date of deliv Month	very Day Year
s, P.O	ires that the dea i signed by the a id be detached f	ρ	Part II. Other significant conditions contributing to death but no Ping Contribution	ot resulting in the un	nderlying cause given in Par				the cause of death?
Division of Vital Records, P.O.	sician: The law require certificate has been si irector, page 2 should b	Completed					vas an utopsy erformed? es 2 No	24b. Were auto prior to co death? 1 \square Yes	opsy findings available ompletion of cause of
/ital	sician: certifical irector,	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Outpatien	Othori	eath (Check only one) Nursing Home 5	tesidence 6	Other (Specif	(v)
) of \	ling Phy n. After this funeral d		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Yea	28b. Time of	28c. Injury at work? M 1 Yes 2	28d. Descri	be how injury o		
ivision	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - building, etc. (Sp.			28f. Location	on (Street and I Town, State)	Vumber or Rura	al Route Number,
	Hospita 24 hours Funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my local Check 2 Medical Examiner: On the basis of examiner.	ination and/or invest	igation, in my opinion, death	occurred at the time, d	ate and place, a	and due to the ca	ause(s) and manner stated.
	To the within To the comple	Ž	only one) 3 Certifying Nurse Practioner: To the best 29b. Signature and title of certifier	/ M M	29c. License number	719	29d. Date	signed (Month,	Day, Year)
5	7		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print) Print) 97	SUITE 1	n GL	EN MODI	3ER 17, 2610 0 MD 21738
	Sta Registr		31. Date filed (Month, Day, Year) DEC 20 2010	1-3	4		U		
			The state of the s	THE PROPERTY OF	· ·				

DHMH 17 Rev 7/2009

0-09639 Seneveive Jankie	ewio	Please Ty	pe or Print	in Black Indel land / Departm	ible Ink. Er ent of Healt	sure All C	Copies Are tal Hygiene	e Legibl e	e.	
		I- For State	nate of mary		ate of Death			Reg. No	2010	4005
Physicia		Registrar 1. Decedent's Name (First, Midd	die,Last)	- 11				of Death		3. Time of Death
Medical Examir		GENEV	TEVE	JANKI	EWIC	22	Dece	mber 14,		1553 hrs
		4a. Facility Name (if not institution 907 South Belnord Av		number)	4b. City, To Baltim	own, or Location of			c. County of Deatl	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last bir	thday) If Under Months			e of Birth (MN		thplace (State or Foreign untry)
Director	l	215-12-1606	1 M 2 F	91	Yrs.		J	7N.2	7,1919	MD.
ku m	ŀ	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location					10d. Inside City Limits
. ₹		iM D		Bul	11:m	RE				1 Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number		ICAL	~7 i M O 10f. Zip (Code		10g. Ci	tizen of What Cou	ntry?
the N		9075 BE	LNOR	D AVE	2	1224	<u> </u>	l	1.5.A.	
with ms 23	Funeral	11. Marital Status	A	ecedent Ever in U.S. Forces?	13. Was Deceder	t of Hispanic Orig Cuban, Mexican			14. Race - Amer White, etc.	ican Indian, Black,
r death	띪		1 Yes	2 2 No				,	Specific #1	111
s afte	2	3 Widowed 4 Di	ivorced If Yes, Give Y or Dates:		Decedent's Usual C	No specify:	kind of work done	e 16b.	Specify: (/	Industry
2 hour	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)	during most of work	ing life. DO NOT	use retired)		,	
036 thin 7 reference	ğ	4		1	tomE 1	MAKER	3	C	n Surname)	OME
5-0 led w Hygie I other		17. Father's Name (First, Middle								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be		KIEL	DICZ	b. Mailing Address	(Street and Num	APN.	ORA ita Number (City or Town State	ZCZUK Zin Code)
, MD 21215-0036 and 2 should be filed within 72 hours at teath and Mental Hygiene. tem 27 is marked other than "natural traumatic event, the Medical Examin	٩	19a. Informant's Name/Relation	1 ship (Type, Pilit)	1	1118 AN	,		_ ,	and the second	21224
e, M 1 and 2 Health item 2	-	20a. Method of Disposition	10 //		of Disposition (Nam		Date	20c	Location - City or	Town, State
MOre Pages 1 tent of H int: If i	-1	1 Burial 2 Crematio		from State crema	tory or other place)	1000	12-18	-10 1	RD/TO	MD.
·= 8391	1	4 Donation 5 Other S 21. Signature of Funeral Service		13/.	22. Name and	Address of Facility			SARV	21274
Balt permit. Depart Impor injury	ı	Thomas a	· Skar	da tr.	SKAR	DAY=H	. 2829	2HU1	DSON .	57.
Physician		23a. Part I. Enter the disease, o failure. List only one cause	or complications that se on each line.	caused the death. Do n	ot enter the mode o	fdying, such as c	ardiac or respirat	tory arrest, st	nock, or heart	Approximate Interval Between Onset and
iNedical ≟xaminer	ı	Immediate Cause (Final disease or condition resulting in death)		erotic Cardiovascı	ılar Disease					Death
Magazine.			Due to (or as	a consequence of):						-
2.	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):						
	Examine	(Disease or injury that initiated events resulting in death) Last	C	s a consequence of):						
ecuted and transit	ă	events resulting in death) Last	d	, ,						
e exec	dica	UNPENDED	AMENDE)						
Box 68760, e death certificate be exe the attending physician of ed for use as the burial -	Physician/Medica	IF FEMALE: 23b, Was decedent pregnant in	41	s, outcome of pregnancy		0 DE-11-1		2	3d. Date of deliver	y Day Year
certifications are as	cian	past 12 months?	,		Fetal death Other (Spec		c pregnancy	90	Month	Day 10ai
Box 6 death cer he attendi d for use	ysi	1 Yes 2 No 9 Ur	nknown 9 Uni	known	Outer (-)					
ords, P.O. B w requires that the d s been signed by the		Part II. Other significant cond			ng in the underlying	cause given in Pa	art I. 236			the cause of death? bably 4 Unknown
S, P	Completed by	heart disease, seizu	ires, bleeding u	licers		-		a. Was an		utopsy findings available
ord w reg as bee	plet							autopsy performed	prior to	completion of cause of
Rec The la	팃							Yes 2	No 1 ✓ Y	es 2 No
Vital Rechysician: The this certificate	Be	25. Was case referred to medic examiner?	Hospital:]		6.Place of Death OA Other	(Check only one Nursing Home		dence 6 🗸 Othe	ar Scana
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rastier death. al Director: After this certificate has been signed by the fluneral director, page 2 should be detach.	욘	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	te of Injury 28b		8c. Injury at Work			njury occurred	-
on of nding Pl th. r: After re funera	ë	1 of Natural	(Mo	nth, Day,Year)		1 Yes 2	No			
ivisior or Attendather death Director: In by the	ficat		vestigation 28e. Pl	ace of Injury - At home,	farm, street, factory,	office building, e			and Number or R	ural Route Number, City
Div	Certification:		termined (Special	<i>fy</i>)			or	Town, State)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	SalC	29a. Certifier 1 Certifying I	Physician: To the b	pest of my knowledge, de is of examination and/or	eath occurred at the	time, date and pla	ace, and due to t	he cause(s) a	and manner as sta	ted. ne cause(s)
To the within To the compl	Medical	~ [4]	and manne			License number			f. Date signed (Mo	
	Σ	29b. Signature and title of certif)/A/J-C	7/ 1/ Rob	St 290	O.C.M.E.			ecember 15, 2	
		30. Name and address of perso	all-	Velle +		J. W. III. III.				
:		30. Name and address of person Victor Weedn MD JD			111 Penn Str	eet, Baltimor	e, MD 21201			

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

32. Registrat's Signature

OCME

Douglas Lavern Jones, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jougias Laveili .		I- For State Registrar	ate of waryland		rtificate o		d Mental		eg. No. 20	10,40054
Physicia Medical Examir		Decedent's Name (First, Midd Douglas	le,Last)		J	ones Jr		2. Date of Deal Month December		3. Time of Death 0326 hrs
		4a. Facility Name (if not institution)		4b. City, Town, or			4c. County of	
		Upper Chesapeake M				Bel Air			Harford	
Funeral Director		5. Social Security Number 301-62-5408	6. Sex 7. As	ge (In yrs. I	ast birthday) Yrs	If Under 1 Yea Months Days		8. Date of Bir lin. 01 1.		Birthplace (State or Foreign OH
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Loca	tion				10d. Inside City Limits
* _	5	MD Hai	ford		Abin	ıgdon				1 Yes 2 No
e Maryland or 28a-f show fied at once,	Director	10e. Street and Number	D			10f. Zip Code	امَم	11	Og. Citizen of Wha	•
vith the s 23a o	圁	3032 Clarkso	12. Was Deceden	t Ever in U	.s. 13. Wa		LOO9	Specify Yes or No	U • S	• A • American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggiene. Important: If item 37 is marked other than "natural", or items 33s or 28s-7 sho injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	1 Never Married 2 XM	Armed Forces 1 X Yes 2 Vorced If Yes, Give Year		lf Y	Yes, specify Cubar	n, Mexican, Puer		White,	
nours a	od be	15. Decedent's Education (Spe		• •	16a. Deceder	nt's Usual Occupat	tion (Give kind o		16b. Kind of Bus	•
36 iin 72 h	plet	Elementary/Secondary (0-12) 12th grade	College (1-4 or 2yrs	5+)		puter (ŕ	W.R. G Davids	race on Chemical
5-00 ed with tygiene other t	Completed	17. Father's Name (First, Middle	_		0011	_	_	ne (First, Middle, N		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	Douglas L.						a A. Sc		
MD 2 d 2 should th and M n 27 is m	٥	19a. Informant's Name/Relations Josephine Jo				,		r Rural Route Num		, State, Zip Code) Md 21009
e, N 1 and 2 Health Fitem 3	ı	20a. Method of Disposition			Place of Dispos	sition (Name of cer ther place)	metery.	Date	20c. Location - 0	City or Town, State
Pages nent of nut: If		1 X Burial 2 Crematio 4 Donation 5 Other S				Forest		Ukn 31/2010/	Baltim	Mills,MD Ore, Md
Baltimore, Permit. Pages I ar Department of Hee Important: If ite	1	21. Sign ture/of Funeral Service	Licensee	A /	Ma	Name and Address	of Facility West	- 3.	•	
Physician	-	23a. Part I. Enter the disease, or		the death						
vedical ≟xaminer		Milure, List only one cause Immediate Cause (Final disease or condition resulting in death)	11			iovascular Dis	sease			Between Onset and Death
		Sequentially list conditions,	b							
	Ē	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	equence o	f):					
cuted and transit	al Examiner	events resulting in death) Last	Due to (or as a cons	equence o	f):			-		
60, ate be exe hysician a e burial -	gic	UNPENDED	AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b, Was decedent pregnant in t past 12 months?	23c. If yes, outco		2 Fe	etal death 3 [Ectopic preg	nancy	23d. Date of d Month	lelivery Day Year
BO ne deat	lys.		known 9 Unknown					Loo. pidde		
Division of Vital Records, P.O. B Is later attending Physician: The law requires that the d as after death. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	ゑ	Part II. Other significant condi	tions contributing to deal	n but not r	esuiting in the i	underlying cause g	given in Part I.			ute to the cause of death? Probably 4 Unknown
aw requir	Completed							24a. Was a autop perfor	sy pri	ere autopsy findings available ior to completion of cause of eath?
Rec The l ficate h	ខ្ញុំ							1 Yes	2 ✓ No 1 [Yes 2 No
Vital Rec ysician: The l his certificate l director, page	a	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	The second second	ent 2 🗸	ER/Outpatient		of Death (Chec	sing Home 5	Residence 6	Other:
ing Phy After th	의	27. Manner of Death	28a. Date of Inj. (Month, Day,	ury	28b. Time of	Injury 28c. inju	ry at Work?	28d. Describe h	now injury occurre	d
ision Attendi	<u></u> ;	1 ✓ Natural 5 Pen 2 Accident Inve	stigation				res 2 No			
Division ospital or Attent hours after death neral Director: y filled in by the	Certification:		Id not be 28e. Place of In	njury - At h	ome, farm, stre	et, factory, office b	ouilding, etc.	or Town, S		or Rural Route Number, City
To the Host within 24 hc To the Fun completely (Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of m miner: On the basis of exa and manner stated.	ny knowled Imination a	ge, death occu nd/or investiga	rred at the time, dation, in my opinion	ate and place, a , death occurred	nd due to the caus d at the time, date	e(s) and manner a and place, and du	as stated e to the cause(s)
E % E 8	ž	29b. Signature and title of certific				29c. Licens				(Month, Day, Year)
		\mathcal{U}				0.C.I	М.Е. 		December 1	4, 2010
OCIVIE		 Name and address of person Mary G. Ripple MD. 	who completed cause of a Deputy Chief Medi			1 Penn Street	, Baltimore,	MD 21201		
Sta	_	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	Farkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 28a-f per me,g910,12/17/2010dhb Certificate of Death Reg. No. for State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Movember Da Day Physician/ 1349 King М Sean Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 8. Date of Birth
(Month, Day, Year)
4-26-1971 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1**x** M 2 □ F Months Days Hours Min. Country) MD **Director** 214-11-6953 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Examiner must be notified 1 X Yes 2 □ No Baltimore MD na 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 Funeral 21206 items 23a 4705 Schley Avenue permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. I file may 1's marked other than "natural", or items; any injury or other traumatic event. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Was Decedent 2.... Armed Forces? 1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Paramedic Fire Dept 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Sylvester King Jacklyn Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21206 4706 Schley Avenue Deshawna King 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) King Memorial Pk 11-24-10 RANDALLSTOWN, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 16 melle 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complete shock, or heart failure. List only one cause or Interval Between Onset and Death Immediate Cause (Final omplications 0 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ျ 2 🗌 No ER/Outpatient 3 DOA 1 Inpatient 2 5 Residence 6 Other (Spec 4 Nursing Home this eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 🛣 No 28d. Describe how injury occurred Operator Certificate: Natural 5 Pending 1843 04/13/2006 \mathbf{p}_{M} 2 Accident 3 Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number, City or Town, State) 500 North Point Road, Baltimore, MD determined Roadway within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title November, 17, 2019 D00 62735 erson who completed cause of death (Item 23a) (Type, Print) Name and address of p

State
Registrar

J DHMH 17 Rev 7/2009

parna Jonnal

Date filed (Month, Day,

Darks

MD 56 2. Registrar's Signature

5601 Loch Raven Blvd, Baltimore, MD 21239

0-09008		Please Type or Print in Black Indelible			gible.	10000
arolyn Keneal	y	State of Maryland / Department 1- For State		lygiene	2010	40056
Dhusisi	/	Registrar 1. Decedent's Name (First, Middle,Last)	or Death	Re 2. Date of Deat	g. No.	3. Time of Death
Physici <u>l</u> edical Exam				Month November	Day Year	2054 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	1
		St. Agnes Hospital	Baltimore			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	() If Under 1 Year If Under 24Hr Months Days Hours Min	,	h(MM/DD/YYYY) 9. Bir Foreig	ın
Director	1	213-20-7933 1 M 2×F 86	Yrs.	April	16,1924 0	untry) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
*	_	MD Baltimore Timon	ium			1 Yes 2 X No
Aaryland 28a-f show <u>i at once,</u>	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once.	Dir	201 Belmont Forest	21093		USA	
h with ms 23 be no	Funeral		Was Decedent of Hispanic Origin? (SIf Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
r deatl	Fun	1 Yes 2 X No		o racan, etc.,		
rs afte ura!", miner	by	3 X Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Dece	Yes 2 X No specify: edent's Usual Occupation (Give kind of	work done	Specify: W II 16b. Kind of Business/	ite
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use re		7.00.1 1.0.00 0.1 200.0000.00	
036 ithin ane.	ďω	12 Hor	nemaker		Own Home	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, M	laiden Surname)	
2121 2121 201d be f Mental marked	o Be	Joseph A. Buser 19a. Informant's Name/Relationship (Type, Print) 19b. Ma		C. McNal		7'- 0-4-)
MD 2 nd 2 shoul ulth and M m 27 is m	ř	N	illing Address (Street and Number or Round Bay Road; S			
and 2 Health item 2		20a. Method of Disposition 20b. Place of Dis	sposition (Name of cemetery,	Date	20c. Location - City or	
DOF ages ages other of		Crest La	rotherplace) awn Mem. Garden 11	/29/10	Marriottsv	ille, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Donation 5 Other Specify: 21. Signature of Funeral Service Lightsee	2. Name and Address of Facility Ste Funeral Home of Ca	rling As	hton Schwa	b Witzke
M FALL	i y	Markey y. Hellen	1630 Edmondson Ave	nue: Cat	onsville.	MD 21228
Physician	y .5	23a. Part I. Enter the disease for complications that caused the death. Do not enfailure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Death
		= 200 to (01 do a control control control				
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
executed in and il - transit		d				
ਹ ਰਵ।	dical	UNPENDED X AMENDED #28f.perME.GG	10,12/20/2010,WS			
Ox 68760, eath certificate be execut attending physician and for use as the burial - tran	sician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
certife certife use as	cian	past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn. Other (Specify)	ancy	Month E	ay Year
Boy death	Physi	1 Yes 2 No 9 Unknown g Unknown	Other (opecary)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	by P	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		pacco use contribute to	
S, P.C					2 No 3 Prob	
cords, law requir has been s	Completed			24a. Was a autops	y prior to c	topsy findings available ompletion of cause of
tal Rec	Com			perform 1 Yes 2		s 2 No
ician: certif	Be	25. Was case referred to medical examiner? Hospital: 1 Input 2 FR/Output	26.Place of Death (Check			
of V; Phys eral di	P.	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time	Sint 0 Bort T Wardin	ng Home 5 F	Residence 6 Other	
DD C	tion	1 Natural 5 Pending Nov 23, 2010 1953 hrs		Subject fell d		
r Atte ter der irecto n by t	fica	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	street, factory, office building, etc.		treet and Number or Ru	
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	4 Homicide determined (Specify) Residence		or Town, St. 7 Monmouta R	ate) oad, Catonsville, MD	
e Hosp n 24 ho e Fund letely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or			e(s) and manner as state	
Di To the Hospital of within 24 hours a To the Funeral I	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.		at the time, date a		
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		November 24, 20	
		famely outhall, MI)	O.O.IVI.E.		14040111061 24, 20	
)		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore, I	MD 21201		
St	at <u>e</u>	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regist	rar	31. Date filed (Month, Day Year) DEC 20 2010 Leave 1. Sanstar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2010 Elizabeth King 9:00 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Timonium Baltimore Lorien at Mays Chapel 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days Aug Month 109, Year 917 West Virginia 1 M 2 X F 232-66-3037 93 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2X No MD Owings Mills Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 335 Timber Grove Rd 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Self Employed Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dawson Hu11 Alice Forrest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 335 Timber Grove Rd., Owings Mills, MD 21117 Susan K. Melton (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Tyler Mountain 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 X Removal from State Injury or Cross Lanes, WV 12/17/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proposto 6 ₽nysician/ Acute my ocor disk Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of siclan and burlal-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death
Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2 100 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending hours after death. neral Director: Aft filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) RO18544 12-14-10 nd address of person who completed cause of death (Item 23a) (Type, Print) SWITE 4105 TOWSON, MD 21209

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

ack

HARLES

32. Registrar's Signature

ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 12:59:43 Ε. Keim 2010 Julius Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Haspital 0 Sinai 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Oct. 19 Year 1921 Hours Days MaryTand 217-14-2260 89 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2XXNo Westminster Carrol1 MD 10g. Citizen of What Country? USA 10f. Zip Code 10e. Street and Number 21157 Funeral 225 Frock Dr., Apt. 329 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1X Yes 2 □ No ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes Give WW II 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) filed within Payrol1 Clerk permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Julius Daniel Keim Mary Francis McDough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3244~Murray~Rd.,~Finksburg,~MD~2104819a. Informant's Name/Relationship (Type, Print) D. Carlyn O'Neill (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 12/17/10 Baltimore, Maryland 4 ☐ Donation 5 🗷 Other (Specify) Entombment 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Eater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastrointestinal Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ disease 1 ☐ Yes 3 ☐ No 3 ☐ Probably 4 ☐ Unknown Coronary artery Completed director, page 2 should alure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic rena autopsy performe Yes 2 No Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 5 \square Pending Natural 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) hardhary 12 15 2010 PAS 18006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Sinai JYOTI CHAUDHARY

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 💪 U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month $2\overset{\text{Year}}{01}0$ Kosicki Witold Watha December 11:33 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Michigan Months Days Hours Min. 1 🕅 M 2 🗆 F 335-24-6247 88 Yrs. Director Usual Residence of Decedent 28a-f shov 10a. State 10b, County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 1 ☐ Yes 2 🔀 No Maryland Baltimore Timonium 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12320 Rosslare Ridge Road 21093 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 6 δ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1940–1945 1 ☐ Yes 2 X No Specify: Specify: "natural", Completed 3 Divorced 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Broker 4 years Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Szendzikowski Witold Watha Kosicki Katarzyna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 12320 Rosslare Ridge Road #207 Timonium, Maryland Mary-Lina Strauff Kosicki (wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, Mount Crematory 12-20-10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home Inc
6500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Death Immediate Cause (Final MESOTHELIOMA Ph_sician/ MALIGNANT disease or condition / Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Due to lor as a consequence of if any beach, to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown sate has been signed by the atte page 2 should be detached for y Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> PROSTATE CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CORONARY ARTERY DISCUSSE 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed After this certificate or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 🗌 Yes 2 No HOSPICO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending To the nosperation 24 hours after death.

To the Funeral Director After the funeral Director After the funeral part of the funeral filled in by th 1 Natural 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KROMMO 6701 N HA QUOS STROOT BALTIMORO MO 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day 3 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician obert 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Days **Funeral** 213-53-3538 MARUL **Director** Usual Residence of Decedent 0d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 Yes 2 □ No the Medical Examiner must be notified at Director Baltimore 10g. Citizen of What Country? 10f, Zip-Code 10e. Street and Number 25A Silver Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic and a second and a second any Injury or other traumatic and a second a second and a second a second a second a second and a second a second and a second a seco 2 No 1 Never Married 2 Married Yes 1 ☐ Yes 2 ☐ No BLACK Baltimore, Maryland 21215-0036 Specify: ş 3 Nidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary, (0-12) College (1-4 or 5+) Beth Labor 174 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) we here 19b. Mailing Address (Street and Number or Rural Route Number, City or Silver Court Balto Wd, 21231 Devoltic 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial ∠ Cremation Removal from State Balto. Cometery 9 60 4 Donat 5 Other (Specif 22. Name and Address of Facility Miller's Metrofelitus Chapel 21. Signature of Funeral Service Lic N. BRODRIVERY e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest List only one cause on each line. 23 Part 1. En the dise shock, or leart failur! Immediate ause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death metastic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to humbolate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a considerence of The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the att 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 2 No 3 Probably 4 🗍 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performet? Yes 2 No certificate has 1 🗌 Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes No Hospital: Inpatient Other: 4 \sum Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 🗌 DOA မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 1 Natural 5 Pending investigation 1 Nes 2 No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours To the Funeral 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 3,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 MARSH JULIA 31. Date filed (Month, Day, Year) 32, Registrar's Si State Registrar

James Anthony Liberto

		l- For State Registrar	Certificate of Death Reg. No.												
Physicia cal Exami	ın/	Decedent's Name (First, Midd	_{lle,Last)} James	Anthony Liberto II				- 1	Date of Death Month Day Year December 18, 2010				3. Time of Death 1945 hrs		
		4a. Facility Name (if not institution University Hospital Sh	_					ocation of	Death		4	4c. County of Death N/A			
Funeral Director		5. Social Security Number Unk		7. Age (In yrs			If Under 1 \ Months [ear ays	If Under Hours	24Hrs. Min.				Foreign	hplace (State or
Director	ļ		1 X M 2 F		+3	Yrs.		İ			OCT 2	0,	196/		Maryland
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town	or Locatio	on								10d. Inside City Limits
≜ .π	٦	MD Baltimore Dundalk									1 Yes 2 X No				
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number					10f, Zip Code				10g. Citizen of What Cou			at Coun	itry?
ith the N 23a or notified		2617 Lynbrook Road					21222			USA					
t be n	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?				If Yes, specify Cuban, Mexican, Pu								ce - American Indian, Black, nite, etc.	
WD 21215-0036 2 should be fited within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fab.			1 Yes	2 X No		1	Yes 2 X No specify:					Specify: White			ite
urs aft tural'	d b	15. Decedent's Education (Spe	or Dates:			Decedent	s Usual Occu	pation	n (Give ki			16b	. Kind of Bu		
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)													
21215-0036 uld be filed within 73 Mental Hygiene. marked other than c event, the Medical	Ĕ	10			Ma	inte	nance			Nama (F	Circt Middle	_	tate (rnment
21215-00; ould be filed with 1 Mental Hygiene 5 marked other tic event, the Me	Be	17. Father's Name (First, Middle John	Casper	т	iber	to			Caro			L.		, Scha	rff
212 uld be Mentz mark		19a. Informant's Name/Relations					Address (S								
MD d 2 sho lith and n 27 is		Carolyn S. Col	llins, mo				Lynbro				Dunda			2122	
Fe, an filter filter frier frier frier frier		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal	from State	cremat	ory or oth					Date	200	c. Location -	City or	Town, State
Baltimore, permit. Pages i a Department of He Important: If ite		4 Donation 5 Other S	pecify:	Me			atory,						Baltim		
Salt ermit. Separti mport		21. Signature of Funeral Service	Licensee Geor	rge Macl	Nabb	22. Na	ame and Add	ress o	f Facility	Cre	mation	ı So	ociety	of	MD, Inc.
Physician	-	23a. Part I. Enter the disease, or	r complications that	caused the dea	th. Do no	ot enter the	99 Free mode of dy	ng, su	<u>r1CK</u> uch as car	ROA!	d Ba. respiratory a	rrest, s	DOTE hock, or hea	MD art	21228 Approximate Interval
/Medical		failure. List only one cause	e on each line.												Between Onset and Death
≟xaminer		Immediate Cause (Final disease or condition resulting in death)		a consequence	of):										
	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):													
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	с	10											
ransit - transit		events resulting in death) Last	d.	a consequence	э от):										
ਰ ਜ਼ਰ	Physician/Medical	UNPENDED	AMENDE)											
760, ficate bo g physic t the bur	/We	IF FEMALE: 23b. Was decedent pregnant in t		s, outcome of pr		. T Eat	al death	3	Ectopic	oregnan	cv	2	23d. Date of Month		/ Day Year
Box 68 e death certil the attending ed for use as	iciai	past 12 months?	4 Pre	gnant at time of	death g		er (Specify)			, , ,					
Bo le deat the at	hys			nown					aa ia Oad		230 Did	tobacc	o use contri	bute to	the cause of death?
, P.O. Box 68 res that the death certif signed by the attending be detached for use as	by P	Part II. Other significant condi	tions contributing	to death but no	t resultin	g in the ur	nderiying cau	se giv	ren in Pan	ι.					pably 4 Unknown
ds, equires	ted										24a. Wa				itopsy findings available
COT law n has b e 2 sh	The part of the past 12 months? If FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Month Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 Yes 2 No 3 Pro 24a. Was an autopsy performed? 1 Yes 2 No 3 Pro 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of deliver Month 28. Did tobacco use contribute to 1 Yes 2 No 1 Pro 24a. Was an autopsy performed? 1 Yes 2 No 1 Pro 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Did tobacco use contribute to 1 Yes 2 No 1 Pro 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury 28. Date of Death (Check only one) 28. Date of Injury 29. Date of Injury 29.							death?	completion of cause of						
Vital Rec ysician: The his certificate		25. Was case referred to medica	al I				26.P	lace o	of Death (0	Check or			NO 1	✓ Ye	es 2 No
Vita ysicia his cer direct	o Be	examiner?	Hospital: 1	Inpatient 2	✓ ER/O	utpatient	3 DOA	0	ther4	Nursing	Home 5	Resi	dence 6	Other	r:
of ing Ph After t	-1	27. Manner of Death	28a. Da	te of Injury		Time of In	· ·		at Work?	ls.			injury occum		-
sion ttendi death. ctor:	atio		Pending Investigation Dec 18, 2010 1830 hrs					1Yes 2 V No			/Charactered Number of Burgl Pouts Number City				
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. Intral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	dete	28f. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)												
B. B. III O 29a Confficer								and manner	r as state	ed.					
To th within To th	Medical	29b. Signature and title of certifi	and manne	r stated.	, androi I				number						nth, Day,Year)
		Ly au						C.M				- 1	ecember		
2		30. Name and address of person		_	em 23a)			_		_					
3	1		ant Medical Ex			n Stree	t, Baltimo	re, N	1D 2120	01					
	tate	31. Date filed (Month, Day, Year)		Registrar's Sign	ature Lacus	13									
Regis	uel	DEC 2 0-2010	General	B. 1	gar							OCM	Ē		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sophie Liberto Month 6.40PM Medical 1 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Robinson U.S.A BALTOMD 21224 Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign (Month, Day Hours Min Director MD (Country) <u> 216-28-7587</u> 79 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Baltimore Mt) MD 10e. Street and Number 10g. Citizen of What Country? Funeral On St Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Black, White, etc. 1 Yes 2 If Yes, Give Year or Date 21215-0036 2 XNO 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 Divorced Specify: White Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) House 8TH Wife Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Casmir Kazprzak Helen Tomchak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5624 North Lane Victoria Watt BALTO, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12-16-1d Glen Burnie Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility KARDA 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Onset and Death COLUN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been si Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 🗌 No Yes 2 1 Yes Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \(\subseteq \text{Yes} \) 28b. Time of 1 Natural 5 Pending Accident 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one Certifying Nurse Practioner: To the built of my knowledge Seat. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

JACKIE D 31. Date filed (Month, Day, Year)

2010

ECEMBER

50 PHI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 December 6:55 A M Lewis Joseph Medical Charles 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Carroll Westminster Carroll Hospice Dove House Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 4, 1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 XM 2 | F Months Days Hours **Director** 511-16-2589 Kansas Usual Residence of Decedent 3a or 28a-f show be notified at 10b County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 'natural", or items 23a **Examiner must** 4115 Ridge Road 21157 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) event, the 12 factorv worker tire mfa 1 and 2 should be filed w f Health and Mental Hygi item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Lewis Grace Guiqus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Lewis/ son 2855 Sommersby Rd. Mt. Airy, MD 21771 permit. Page 1 and 2 Department of Healtl Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State injury or 4 Donation 5 Other (Specify) All County Cremation | 12/13/2010 | Sykesville, MD 21. Signature of Buneral Service Licensee 22. Name and Address of FacilityHartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line? Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate Yes 2 🔽 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Yes 2 9 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide after death Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the lasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nur 29b. Signature and title 29d. Date şigned (Month, Day, Year) 1) 20806 10/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Restorstaun BUSINOSS (

DHMH 17 Rev 7/2009

State Registrar filed (Month, Day, Year)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ HA DECOMPOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** (Tilenes Baltor Cor 10Wson NOSPICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** -01359 Months Days Hours Min. (Month, Day, 1 M 2 F 6 Yrs. Director MAR Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Nes 2 □ No BOLTIMORE Md. 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 21223 USA Edwarson Ave Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever ip U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. ō ρ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural". 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) a 1 and 2 should be filed within 72 of Health and Mental Hygiene.
If item 27 is marked other than 6 Elementary/Seconday (0-12) College (1-4 or 5+) Old 2065 Labor UKA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ AL 19a. Informant's Name/Relationship (Type, Print) PROWER 19b. Mailing Address (Street and Number or Rural Route Number, City o Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra McClveen Sames 1) n I Jers Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 15 ☐ Other (Specify) etto C Remotore 10 Balte. 21. Signature / uneral Service License en 639 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . h, sician/ UNG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Day Month Pregnant at time of death 2 No ate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death?

1 Yes 2 No To the Hospital or Attending rilysecommular to the Hospital of Barth.

To the Funeral Director: After this certificate this certificate Yes 2 🗗 25. Was case referred to ical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 2 7 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 0 Other (Specify) 27. Manner of Seath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Matural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) DECOMBER address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 20 2

DHMH 17 Rev 7/2009

Registrar

10-09654							
Pichard Mairose							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

ichard Mairose		State of Maryland / Department of Health and Mental Hy -For State Certificate of Death		201 Reg. No.	0 40065								
Physician	7	Registrar 1. Decedent's Name (First, Middle,Last)	Date of Dea Month	ath Day Year er 15, 2010	3. Time of Death 0552 hrs								
Medical Examiner		Richard Mairose 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Decembe	4c. County of De									
		1513 Olmstead Avenue Baltimore											
Funeral Director		5. Social Security Number 6. Sex 1 X M 2 F 7. Age (In yrs. last birthday) 37 Yrs. If Under 1 Year If Under 24Hrs. Months Days Hours Min.	7	7, 1972	Birthplace (State or Foreign Country) Maryland								
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits											
≹ .″		Maryland Baltimore Middle River			1 Yes 2 X No								
ith the Maryland 23a or 28a-f sho notified at once	10e. Street and Number 2123 Firethorn Rd. 21220 USA												
r death wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year 1993/99 12. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		o- 14. Race - An White, etc									
urs aft tural"		15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	vork done	16b. Kind of Busine									
11215-0036 Id be filed within 72 hours afte fental Hygiene. Tarked other than "natural", the Medical Examine.	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 2 during most of working life. DO NOT use retired to the control of the con	ck Driver Co										
21215-0036 Muld be filed within 72 Mental Hygiene. Revent, the Medical	וכ	17.1 dillet a Marile (1 list, Middle, Edst)	, ,	First, Middle, Maiden Surname) arie Heacock									
212 nould be d Ment is mark	0	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
, MD and 2 sho ealth and cm 27 is	- 1-	Rodney Bruce Mairose (Father) 929 Wampler Rd. Balting	Date	20c. Location - City									
TOFE Dages 1 Ent of H nt: If it		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Maryland Veterans Cemetery	12/28/2	10 Garris	on Forest, MD								
Baltimore, MD 2' permit. Pages I and 2 should Department of Health and Mc Important: If item 27 is an injury or other traumatic	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funera 1407 Old Fastern A	venue	Essex. Mar	yland 21221								
Physician		23a Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or	r respiratory at	rrest, shock, or heart	Approximate Interval Between Onset and Death								
xaminer	İ	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mixed Drug (Heroin, Alprazolam and Condition resulting in death) Due to (or as a consequence of):	Tonaze	Dalii)	South								
4	اچ	Sequentially list conditions, If any, isauling to immediate Due to (or se a consequence or)											
	틝	cause. Enter Underlying Cause (Disease or injury that initiated											
te be executed ysician and burial - transit	Exal	events resulting in death) Last Due to (or as a consequence of): d											
O, e be executed sician and burial - trans	edical	✓ UNPENDED ☐ AMENDED item 23a,27,28a-f per ME 1/18/11 G911 EG											
on of Vital Records, P.O. Box 68760 ending Physician: The law requires that the death certificate ath. The This certificate has been signed by the attending physhe funeral director, page 2 should be detached for use as the bear funeral director, page 2 should be detached for use as the bare funeral director.	5 I												
P.O. B s that the de gned by the e detached i	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3												
ts, P quires ti en signo uld be d	ted b		24a. Wa	s an 24b. Were	e autopsy findings available								
of Vital Records, ag Physician: The law required the three certificate has been someral director, page 2 should	24a. Was an autopsy findings average performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 1 ✓ Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N												
Vital ysician:	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other,4 Nursin	ng Home 5 Residence 6 🗹 Other: Scene										
fing Phy After th	읽	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe	e how injury occurred									
Division tal or Attendi rs after death. at Director: A led in by the fu	gati	2 Accident Investigation found found Investigation 290 Place of Injury - 4t home farm street factory office building etc.	NOWN (Street and Number o	Rural Route Number, City									
Divi	Certification:	3 Suicide 6 X Could not be determined (Specify) residence Country State 1513 Olmstead Balt, MD 21226											
	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)	d due to the ca at the time, dat	use(s) and manner as te and place, and due	stated. o the cause(s)								
To the within To the comple	We	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)										
		fills (O.C.M.E.	December 15, 2010										
		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	ID 21201										
Sta Registr	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPtI,25 per me_g910_12/17/2010dhb
Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ROLAND WOVERBER 10 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. HESTER RIVER MANOR Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yea 6/26/39 5. Social Security Number **Funeral** Days Months Min. 1**⊠**M 2□F Hours 213-36-6238 Marvland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director MD Kent Millington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 139 Clearspring Place 21651 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces:
1 Mayes 2 □ No
If Yes, Give
Year or Dates: 1965-67 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: δ Specify: 3 Widowed 4 Divorced White Completed th and Mental Hygiene.
7 Is marked other than "natur traumatic event, it a Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner 12 Tavern 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည William B. Marney Minnie Duvall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 Is any Injury or other trau once. 139 Clearspring Place Millington , MD Mrs. Frances Marney Wife 21651 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Barial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 11/15/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee Baltimore, Maryland 21229 3620 Wilkens Ave. 23a. Part 1. Enter ye disease, or compli shock, or he if failure. List only Approximate Interval Between Onset and Death nion, that caused the deat cause on each line. Fo not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Vbuman1A /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached if Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BAETERIAZ FRANCAZDITIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown due to osteomyelitis and diskitis of 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **X**No T1 and T2 due to continuous bacteremia due to endocarditis 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1X Yes 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manger stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/13/10 00060301

State Registrar 31. Date filed (Month, Day, Year) **TEC 1 7 2010**

30. Name and address of person who completed

MILLHAREZ

of person who completed cause of death (Item 23a) (Type, Print)

ATMEN M 123 Steel P)

ay, Year)

32 pegistrar's Signature

1 7 2010

August B. Bank

Fax to ME

STES CHOSPENTAND MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Annie Mae Miller November 28. 1:50 a M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Co. Dove House Westminster If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Hours Aug 8, 1913 A Tabama Director 220-36-4085 97 Usual Residence of Decedent 3a or 28a-f show t be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Bluebird Lane 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔼 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: white Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Wideman Lurley Fluker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 235 Highmeadown Rd Reisterstown, MD 21136 Roy A. Miller, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Dulaney Valley Mem 11/30/10 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Rd Reisterstown, MD 21136 Eline Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to a r as a consequence of Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury AMINER that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) is certificate has been signed by the attending physician director, page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 4 Pregnant a Pregnant at time of death 5 Other (specify) g 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform or Attending Physician: The 1 🗌 Yes 2 - No Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? assister မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ning in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes injury 5 Pending Division 2 No Accident Suicide after death Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

17

32 Registrar's Signature

Poole Rd, Westmin Ster MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Day 14 Physician/ Month MCCIONO 1256 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimere Secon Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last hirthday) 8 Date of Righ Birthplace (State or Foreign Country) Funeral (Month, Day, Min 1 🗆 M 2 🗓 **Director** 75 212-32-8899 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ~ 00 once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5517 Stonington Ave 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 XNo Specify: Black Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade Housekeeper Hospital na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Melissa Dawson Cecil Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5517</u> Jacqueline Burke-Daughter
20a. Metflod of Disposition 20 Stonington Ave Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Donation 5 Other (Specify) Arbutus Memorial Park 12/21/2010 Arbutus, Md Simatur of Funeral Service Licensee 22. Name and Address of Facility March F/H West Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ ongutive disease or condition / Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year 2 K No the a 🗍 Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24 hours after death.

9 Funeral Director: After this certificate has been signal and in by the funeral director, page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) Steam - Thompson, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m.D. Thomps on 31. Date filed (Month, Day, Year) State 20 Registrar

DHMH 17 Rev 7/2009

amend #17 Per FH G910 12/29/10 Health and Mental Hygiene Company Compa 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Year Dec 01 19A M Letha M. McDuffie 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Agnes HOCKITON Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2X F Director 8-15-1919 2-22-0832 N.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hyglene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medicel Expriming to nature traumatic event, the Medicel Expriming to mait terrofilled in Director 1 TyYes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 E. Street Madison USA Funeral 21205 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ģ 1 ☐Yes 2 ☐No Specify: Specify: 3 XWidowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glenn L. Martin yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McLeod McDuff ၀ Sam Lula Mae Adams 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6700 Yataruba Drive Balto, MD 21207 6700 Yataruba Drive <u> Madeline A. Loyal-</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 12/20/2010 Arbutus, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H embros Balto, MD 1101 E. North Avenue 21202 weening 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acuto disease or condition resulting in death) Days /Medical Due to (or as a consequence of): Examiner Failur secondary to Keipisatory Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran requires that the death certificate be exec Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by with 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No Hospital or Attending Physician: The certificate Vital 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation death. 2 Accident 1 □Yes 2 □No within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AAMICAN, MIN P23612 Dec 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DHOS ADHIKARI 900 s. caton Baltimor, MD 21229 DURGA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER Day 8 Physician/ 2010 9:55 Ам MARIE MARY FRANCES NELL Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death FREDERICK Examiner 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2 🛛 F Adams Co.. Yrs Director 162-22-3346 88 Usual Residence of Deceder ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Frederick Frederick 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1900 Rosemont Ave 21701 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Housewike N/A Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oft any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Lula Mary Virginia Brown Oscar W. Gouker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mitzi R. Miller 11870 Nicholson Rd Keumar, MD 21757 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🌠 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) New Oxford Cemeteru Dec 13, 2010 New Oxford, PA 17350 22. Name and Address of Facility Feiser Funeral Home, Inc. 21. Signature of Funeral Service Licenses Lincolnuay West New Oxford, PA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an each line. Onset and Death Immediate Cause (Final Priysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death , the ; signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has the director, page 2 s performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 🗆 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: I Director; After to in by the funeral 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 \square Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined n 24 hours after e Funeral Dire eleted filled in b City or Town, State) Medical Ecrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and little of cer 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatu

State

Registrar

20

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:45 PM 2010 Ogonowski December Anthony Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford <u>Forest Hill</u> Rock Spring Village If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Hours Min Mary Land 1 ☑ M 2 ☐ F 8/20/1923 **Director** 216-18-6749 87 28a-f shov 10b. County and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Harford <u>Bel Air</u> 10f. Zip Code 10g. Citizen of What Country? Funeral 1461 Valbrook Court North 21015 S. mit. Page 1 and 2 should be filed within 72 hours after death vartment of Health and Mental Hygiene. sortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 XWidowed 4 ☐ Divorced Completed WWII White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Soap Manufacturing Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kostencza Bednarska Wladislaw Ogonowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adele Bloch (Daughter) 1461 Valbrook Court North Bel Air, Maryland 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetev Overlea, Maryland ^{22. Name and Address of Facility} Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, 21. Signature of Funeral Service Licenses Maryland 21221 23a. Part 1. Enter the disease, or complications that solved the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between marana mucelo Due splestic Immediate Cause (Final Onset and Death Ph_sician/ 24800 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the attending physician and hed for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEDYESSION Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 performed? Yes 2X No certificate 1 ☐ Yes 2 ☐ No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Assisted Hospital Other: 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify Living ᅆ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completed fil 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Receipe 12/15/2010 D 0023170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 208-C, Pleamtree Rd, Belair, MO S. Ragaraj. mo 21015 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 0 2010 garke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07:25P M Henry J. Oxendine Jr. 87 2010 Medical 4a. Facility Name (if not institution, give street and number)
Glen Burnie Health and Rehab Town, or Location of Death 4c. County of Death Examiner 4b. City, Glen Burnie Anne Arundel Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 216-36-8972 **X** XM 2 □ F Months 1476471929 81 N.C. **Director** Usual Residence of Decedent of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Anne Arundel MD Curtis Bay 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21226 5021 Pennington Ave USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2 No Specify: SpecifyAmerican Indian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Construction **Gyrs** Construction Worker Be 18. Mother's Name (First, Middle, Maiden Surname)
Unavailable 17. Father's Name (First, Middle, Last) Henry Oxendine Sr. 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Oxendine Son 4602 4th St Apt 2 Brooklyn Park MD 21226 it of Healt : If item ? / or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crem 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 2/20/2010 Glen Bernie MD Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem Thomas Allen PA 7090 Ridge RD Signature of Funeral Service Licensee & Fun Ser Hanover MD Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MON Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 K Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Box 68760 Records, P.O. Division of Vital the Hospital or Attending

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

-501h

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ RANK 2201N Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COCH RAVEN COMMUNITY LIVINGE 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 反 M 2 🗆 F Months Days Hours Min (Month, Day, Year MARYLAND 88 Director 213-16-3732 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director FLA PINELLAS LARGO 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1915 SEMINOLE BLVD LOT 132 33778 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian. Armed Forces?

1 XYes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married hours after Maryland 21215-0036 Hygiene. other than "natural", 1 ☐ Yes 2 😾 No Specify: Specify: WHITE Completed 3X Widowed 4 □ Divorced Year or Dates. 1942 – 45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business industry (Specify only highest grade completed) 72 BELFORT INSTRUMENT Elementary/Seconday (0-12) College (1-4 or 5+) 11 COMPANY <u>MACHINIST</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F 2 HENRY POLAND CECELIA (KRAEMER) 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, BARBARA SMITH/DAUGHTER BALTIMORE, MD 5839 DAYBREAK TERRACE 21206 f Health Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date Page 1 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS 12-23-10 OF FAITH BALTIMORE, MD 22. Name and Address of FacilityCVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence or). Exam Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 nding p use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 L Yes 2 L 9 D Unknown the 9 Unknown P.O. signed by t d be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After iniury 1 🛮 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year

Registrar
DHMH 17 Rev 7/2009

00

LOCH RAVEN BLUD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Michael Precht 12:38 PM December 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 1 🔀 M 2 🗆 F 215-46-8883 Director 63 Nov MD Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Baltimore MD Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 1913 Quentin Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 should be filed within 72 hours aftinand Mental Hygiene. If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. White Specify: 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) District Court Commissioner 12th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret H. Bandell James R. Precht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1913 Quentin Road Baltimore MD 21222 Michael Precht Sr. /son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Holly Hill Cemetery 12/18/10 Baltimore MD 1 🗶 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signavry of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the cleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Myocardial infarction disease or condition resulting in death) 5 days Medical Due to (or as a consequence of): Examiner 13 years disease Coronary artery Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last The to (or as a nonsequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à colon cancer with liver metastasis 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) miles S. Cuhran, MD BES - 000 December 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer 4940 Eastern Avenue Baltimore, WD 31334 MD Cuhran

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

32. Registrar's agnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 16, Physician/ 2010 9:40 P M Robert Lee Pugh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Funeral 6. Sex (Month, Day Year) ec. 29, 1919 North Carolina 1 XM 2 F Days Director 218-12-4124 90 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland Harford Bel Air 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code by Funeral USA 1122 Spalding Drive, Unit A Bel Air Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc 1 🕅 Never Married 2 ☐ Married Yes 2 XNo 1 ☐ Yes 2 XNo Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should te filed within 72 hr. Dep rtment of Health and Mertal Hygiene. Important: If item 27 is marked other than "ma any njury or other traumatic event, the Mediconc. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Custodian 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Sarah Cordelia Roupe Ambrose Franklin Pugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Ccde) 1122 Spalding Drive, Unit B, Bel Air, Maryland Paul Pugh / Brother 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Burial 2 ☐ Cremation 3 ☐ Remova Bel Air Memorial Gdn. 12/20/2010 Bel Air, Maryland 4 Donation 5 ther (Specify) ture of Funer 22. Name and Address of Facility McComas Funeral Home P.A. 21. Sign 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, isduing to initioante cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: မြ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m.D.31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month PURPER **Physician** 38PM GRACE 2010 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 👿 F 12 MD Director Dec. 2010 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show if than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Westminster Director MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 774 Windsor Drive 21158 death \ by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status e filed within 72 hours after de al Hygiene. Black, White, etc. 1 □Yes 2 □Xo 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien Important; if item 27 is marked other that any Injury or other traumatic and Important. never worked 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tracy Marie Shifflett Matthew John Purper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 774 Windsor Dr., Westminster, MD 21158 Mrs. Tracy Purper (mother) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Meadowridge Memorial 12-21-10 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Page Haught of P.O. Box 195 Sykesville, MD 21784 erpert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DISSEMINATED INTRAVASCULAR COAGULOPATHY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VER MASS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and abe detached for use as the burial-transit PREMATURIT Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has all director, page 2 autopsy performed? 1 ☑Yes 2 ☐No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1649502162

Registrar DHMH 17 Rev 1/200

DEC 2 0 2010

Omenun

CHINAZO MENIRU

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

DEC, 16, 2010

SOUTH GREENE STREET, BALTIMORE, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Patricia E Payton 10:30 A M December 2010 Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Union Memorial Hospital Baltimore Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral Country) MD Days 1 □ M 2 🕱 F 57 0772671953 Director 11 KROWA 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyclene. Director Baltimore Baltimore 28a-f MD ¹XXYes 2 □ No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21218 3601 Greenmount Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married "natural", or 1 Yes If Yes, Give 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates ?7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Teacher 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+)
2yrs Elementary/Seconday (0-12) Education Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jessie Robert McLendon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Andrew Payton Son 1101 East 20th St. Baltimore MD 21218 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crem 12/13/10 Glen Bernie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Ser ThomasAllen PA 7090 Ridge RD HanoverMD 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Palmonary Massive disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ng physician and as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 2 🗌 No been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy
performed?

1 Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 ☐ Yes 2 🔀 No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier AT 2438946 MD Ocember 10,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Hanna

201

East

University

32. Registrar's Signature

Parkway

Baltimore

Maryland 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ George Carl Patschke 2010 5:55 A. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Smeton Place #204 Baltimore Towson 8. Date of Birth Jan 13, 5. Social Security Number . Sex 1 ፟ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) Washington D.C 1932 Director 213-30-7831 78 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Maryland Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? Funeral 1 Smeton Place #204 21204 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married 2 🗌 No altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: "natural", 3 Divorced Year or Dates.1952**–**1956 White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 years Elementary/Seconday (0-12) Station Technician Television Broadcasting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harold Earl Patschke Margaret Sylvia Simonson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Rae Patschke (wife) #204 Towson, 21204 Smeton Place Marvland 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Dulanev Valley Memorial Grdns. 4 ☐ Donation 5 ☐ Other (Specify) 12-21-10 Timonium, Maryland ame and Address of Facility Chell-Wiedefeld Funeral Home Inc. 5500 York Road <u>Baltimore, Marylar</u> 21. Signature of Funeral Service Licensee 21212 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ en disease or condition resulting in death) Medica Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 400 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) amoures D52016 2,21 December 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)
NEC 2 0 2010

32. Registra 's Signature

ous +

31 N

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#1,29d, perPHYS, G910,12/20/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 14 Pay The lma Roberts Mary 2ďľo Dec. 9:15 Рм Thelma Roberts Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 957 Radcliffe Road Towson Baltimore 5. Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday Year 8. Date of Birth **Funeral** Months Days Hours March Day, 1 🗆 M 2 💢 F Director 219-10-1489 97 Yrs 191 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 957 Radcliffe Road USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William John Kraus Catherine E. Winter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra K. Roberts, daughter 957 Radcliffe Road Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Cremation 3 Removal from State cemetery, crematory or other place) Metro Crematory Inc. 12/15/10 Baltimore, Maryland 21. Signature of Funeral Service Licenses remation Society Of Maryland, Inc 99 Frederick Road Baltimore, Mary Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Pnysician/ Seczon disease or condition Medical resulting in death) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown the detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 🗌 No Yes 2 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending work? 1 ☐ Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Year)

DHMH 17 Rev 7/2009

7501

32. Registrar's Signature

OSLERIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland / Dep	artment o				CUI	0	+0080
	Physici		1. Decedent's Name (First, Middle, Las	1		rimoato	0, 000		2. Date of Dea	Day	Yeer	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give	eal street and number)		To	وكرر	ation of Death		4c. Count	610 y of Death	TORE
	Funeral Director			ex 7. Aga ☐ M 2 文 F	e (In yrs. last birthday, 95 Yrs.	Months D		Jnder 24 Hrs. ours Min.	8. Date of Birt (Month, Day 10/20/	1915	9. Birthi Cou MAR	place (State or Foreign ntry) YLAND
	show	or	Usual Residence of Decedent 10a. State 10b. County MD BALTIM	ORE	10c. City, Town or L							10d. Inside City Limits 1 ☐ Yes 2 XNo
	with tha Marylan a or 28a-f show be notified at	Direct	10e. Street and Number 1323 ROSEWICK	AVE		10f. Zip Co		1237		10g. Citizen of What Country?		
980	iges 1 and 2 should ba filed within 72 hours after death with tha Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinational be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 M If Yes, Give Year or Dates:	No.	Was Deceden If Yes, specify	t of Hispan Cuban, Me		pecify Yes or No- Decify Yes or No- Decify Yes or No-		ck, White,	can Indian, etc. I T T E
21215-0036	I within 72 ho iene. r than "natur the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 1 2	ducation de completed) College (1-4or 5	(Give	dent's Usual C kind of work of DO NOT use i	done during retired)	g most of won	king	16b. Kind of E		dustry
Maryland 2	should ba filed within ind Mental Hygiene. s marked other than "umatic event, the Med	To Be C	17. Father's Name (First, Middle, Last) LAMBERT C •				18. 7	Mother's Nam	ne (First, Middle,	Maiden Surnai		
Mary	and 2 should I saith and Meni n 27 is marke iar traumatic		19a. Informant's Name/Relationship (TMICHAEL BERTCI						ral Route Numbe			.,
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or othar tra once.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Disp	osition (Name matory or other	of or place)		Date	20c. Location	- City or To	own, State
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licen	See See	2	2. Name and A	Address of F	Facility CV		SEDALE	FUN	ERAL HOME 21237
8760, %	death certificate be executed Water and for use as the buriar-transit defor use as the buriar-transit	Ical Examiner	23a. Part1. Enter the disease, or comy shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	the death. Do not enternable Roke a consequence of): Rlipid a consequence of): RReview	etia etia	of dying, suc	ch as cardiac	or respiratory ar	rest,	â	Approximate Interval Between Onset and Death
Box 6	that the death certifica ad by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	⊒Ectopic pregr □ Other (speci					ate of deliver	ery Day Year
rds, P.	quires that n signad b uld be deta	by	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the u	nderlying caus	se given in I	Part I.	23e. Did to			he cause of death?
	The law requires that the cate has been signed by the page 2 should be detache	Completed								rmed?	Were autoprior to codeath?	opsy findings available imptetion of cause of
Division of Vital	To the Hospital or Attending Physician: Th within 24 hours alter death. To the Funaral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injui (Month, Day	ury - At home, farm, st	f 28c.	Other: 4! Injury at Work? 1 Yes	Nursing H	28d. Describe h	dence 6 □Otl	rred	fy) al Route Number,
Q	To the Hospital or Attent within 24 hours after deatl To the Funaral Director: completely filled in by the		29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of	of my knowledge, deal	h occurred at t	he time, da	ate and place,	and due to the	cause(s) and m	anner as s	stated.
	To the Hospital within 24 hours To the Funaral completely filled	Medical	one) 29b. Signature and title of certifier	and manner sta	ited.	29c. L	icense num	nber		29d. Date signs		
	1		30. Name and address of person (po	completed cause of de	CRNP eath (Item 23a) (Type,		1315	555		12/15	5/2	010
			6095 Mare 31. Date filed (Month, Day, Year)	shalee	DR E		D6E	MD	2107	5		
	Sta Registr		DEC 2 0 2010	news &	barket							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	State of Mar	yland / Dep	partment of I	Health and	Mental Hy	giene		
			State Registrar		Ce	ertificate of l	Death		Reg. No.	10	÷0081
	Physicia	in/	Decedent's Name (First, Middle, Last)	0				2. Date of De		_Year	3. Time of Death
	Medic	al	WORMAN	Ranso	m			Month	1	210	5 83 AM
	Examin	er	4a. Facility Name (if not institution, give stresson Hospice	•		4b. City, Town, o	r Location of Dea . 11stow:		4c. County		
/	Funeral		5. Social Security Number 6. Sex		n yrs. last birthday		IISCOW		Balt		lace (State or Foreign
	Director				7 5 Yrs.	Months Days	Hours Mir		, Year) -1935	Count	
	A		Usual Residence of Decedent						1000		
	yland f sho ed at	혅	10a. State 10b. County	11	0c. City, Town or L					10	Od. Inside City Limits
	28a- otifie	Funeral Director	MD Balto		Turner	Station					1 🗆 Yes 2 🔀 No
	th the 3a or t be r	al	10e. Street and Number	1		10f. Zip Code			10g. Citizen of W	hat Coun	try?
	ith wi	nue	617 New Pitts	Durg Ave		212		Canaify Van av Na	USA		
0	er deg or ite niner		11. Marital Status 1 Never Married 2 Married	Armed Forces?		Was Decedent of H If Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)		e - America k, White, e	
က္တ	rs aftural", Exar	ed k	3 X Widowed 4 □ Divorced	1 Yes 2 □ No If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No	Specify:		Specify:	Bla	ack
5-0	hour "natu dical	Completed by	15. Decedent's Educ (Specify only highest grade	ation		edent's Usual Occup		orkina	16b. Kind of Bu	siness Ind	ustry na
2	hin 7%	mo	Elementary/Seconday (0-12)	College (1-4 or 5+)	life.	DO NOT use retired)		Orking			na
N N	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	12th grade 17. Father's Name (First, Middle, Last)			anitor					
and	be filed lental Hy rked oth tic event	10 E	Shirley Ransom					ame <i>(First, Middle,</i> oldia Yo	,	,	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho arumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type,	Print)	105 145	ling Address (Street				-1- 7:- C	
	1 and 2 should be filed wit of Heatth and Mental Hygie item 27 is marked other other traumatic event, tt		Glorious C. Woo		- 1	New Pi				ane, zip C	Station,
ē,	1 and 2 s of Health item 27 other tra		20a. Method of Disposition		20b. Place of Disp	osition (Name of	-	Date	20c. Location -		
Baltimore,	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ⚠ Donation 5 ☐ Other (Specify)			matory or other place ille Ve	· i	-21-201	0		11
aĦ	permit, Page Department Important: I any injury o		21. Signature of Funeral Service Licensee	10		22. Name and Addre			East F		lle, MD
20	88 = 88		Vinetto	K- Jones		1101 E	. North	ı /Avenu			ID_21202
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one of	ations that caused the cause of each line.	e death. Do not er	ter the mode of dyin	g, such as cardia	ac or respiratory arr	est,		Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	Gre	bral	Thro.	n hose	Ġ			Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):	•	-				
		er	Sequentially list conditions, b.	Due to (or as a co							
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a co	onsequence oi):						
	be executed sician and burial-transif	Еха	that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of):	-				\rightarrow	
3	ate be executed physician and the burial-transit	dical	Ld								
2,0	certificate nding physuse as the	Ned									
χ 20 20 20 20 20 20 20 20 20 20 20 20 20	endin	an/I	zob. Was decedent pregnant	. If yes, outcome of p		Ectopic pregnanc	ev.		23d. Date	e of delive	ry
X R R	death he atte ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tin		Other (specify)	- 7		Mon	th I	Day Year
j	law requires that the nas been signed by the e.2 should be detach	Phy	Part II. Other significant conditions contri	ibuting to death but r	not resulting in the	underlying cause di	en in Part I	Dog Did to	h		
٠ <u>٠</u>	res this	d by	Tarim Care again Care a Contact of Contact o	outing to doutin but i	to resulting in the	andonying oddoo gi	on in raich	1 🗆 🗎			ably 4 Unknown
ğ	requir been	etec		_				V			
VItal Records,	has by	Completed						24a. Was a autop	sv pi		sy findings available apletion of cause of
ř	n: The ficate or, pag		25. Was case referred to medical					1 Tes		☐ Yes	2 No
Ta VII	s cert	To Be	examiner?	pital:	2 ER/Outpatie	_ Toth	ace of Death (Ch		A PONT	00	pel
0	g Phy er this neral c		27. Manner of Death	28a. Date of injury (Month, Day, Ye	28b. Time	of 28c. Injur	y at	Home 5 Resid	ow injury occurred		
0	endin eath. or: Aft	ficat	1 Natural 5 Pending 2 Accident Investigation	(IVIOTILIT, Day, Te	ea <i>r</i>) injury	M 1 🗆	Yes 2 No				
UNISION	r Atterder de irecto	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S		reet, factory, office		28f. Location (S City or Tow	treet and Number	or Rural I	Route Number,
5	oital o urs af ral Di							4			
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 harurs after death within 24 harurs after death. To the Furthar Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as it	Medical	29a. Certifier 1 ertifying Physicia (Check 2 Medical Examiner:	On the basis of exam	nination and/or inve	stigation, in my opinio	on, death occurred	d at the time, date a	nd place, and due	to the caus	se(s) and manner stated.
	orthe orthe	Σ	29b. Signature and title of certifier	ractionen To the bes	it of my knowledge	29c. License			29d. Date signed		
	F>F0		1000	8X//	hme	L D1		l l			
			30. Name and address of person who comp	pleted cause of death	n (Item 23a) (Type.		- /	, , ,	1	1,	21061
			Characa Bo	B 693	N.A.	nin N'a	5 B1	lud 5	n ID	N	2106/
	Stat	е	31. Date filed (Month, Day, Year) DEC 2 0 2010	32. Registrar	ignatura a						
	Registra	r	DEO SO TOTO	1							

DHMH 17 Rev 7/2009

Charles Randofh		dmond, Jr. 1- For State	State of	f Maryla			nent of cate of			Menta	al Hyg		.	201		40082
Physicia		Registrar 1. Decedent's Name (First	t, Middle,Last)				oute or i	Journ			2.	Date of De				3. Time of Death
Medical Exami		Charles Randolph Redmond Jr									Month Novembe				1102 hrs	
		4a. Facility Name (if not in Doctor's Commu			umber)		41	city, To Lanhar		Location of	Death			County of Corince Ge		S
Funeral		5. Social Security Number			7. Age (In		irthday)	If Under							9. Birth Cour	place (State or Foreign
Director		212-70-388	1[-]M	2_F	54	4	Yrs.	Months	Days	Hours	Min.	09/1	2/1	956		MD
ily		Usual Residence of Dece 10a. State 10b. 0	County		10c.	City, Tow	n or Locatio	n							1	10d. Inside City Limits
nd show a		MD Pr	cince 0	eorg	e '\$	N	ew Ca	arle	ton	L						1 Yes 2 No
Maryla 28a-f	Director	10e. Street and Number 6608 Adri	an Str	eet				10f. Zip 0		0784			-	zen of What	Count	ry?
death with the Maryland or items 23a or 28a-f show any must be notified at once.		11. Marital Status			cedent Ever	in II C	13 \Mas	Doceden				ify Yes or N		USA	Americ:	an Indian, Black,
eath w items ust be	uneral	1 Never Married 2	Married	Armed F	orces?	No				, Mexican, I				White, e	etc.	
after d	Dy F	3 Widowed 4	Divorced If	Yes, Give Year Dates:	ar			res 2						Specify:	√hi	
hours "natur Exam		15. Decedent's Education Elementary/Secondary		highest grad		_		st of worki	ing life.	DO NOT u				Gind of Busin		
036 thin 72 ne.	Completed	Liomonary	(0.12)	2	, , , ,	T	ruck	Dri	ver				ا ا	elive	згу	
215-0036 be filed within 77 ntal Hygiene. rked other than ent, the Medical	Be Co	17. Father's Name (First, Charles R	_{Middle, Last)} Randolp	h Re	dmon	d Sr			1			irst, Middle, ta Ar		Surname) amoni	t	
24 Ould I Me	ToE	19a. Informant's Name/Red		e, Print) Sis	ter		9b. Mailing 26859									Zip Code)
e, MD I and 2 sh Health and item 27 is		20a. Method of Disposition		,		20b. Place	of Disposit	on (Name	e of cerr			Date		Location - C		own, State
MOre Pages l ent of l r other		1 Burial 2 Cre 4 Donation 5 10 0		Removal fr	rom State	Att	antion of other	C Cr	em		12/	7/10	G	len 1	Ber	nie MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Functal S		4			22. Na Tho	me and A	ddress	of Facility en F	Simp A 7	ligit 098°F	Yag	rem e RDI	& F Han	un Ser lover MD
Physician		23a. Part I. Enter the dise failure. List only one			aused the c	leath. Do	not enter the	mode of	dying, s	such as ca	rdiac or re	espiratory a	rest, sho	ock, or heart		Approximate Interval Between Onset and
xaminer	-	Immediate Cause (Final or condition resulting in d	disease a. H	pertensi	ve Ather		tic Cardio	vascula	ar Dis	ease					-	Death
* 1 North		Sequentially list condition		e to (or as a	a conseque	ice or).										
	iner	if any, leading to immedia cause. Enter underlying	ate Du Cause	e to (or as a	a consequer	nce of);										
F. 8 15	Examine	events resulting in death) Last Due to (or as a consequence of):														
Box 68760, the death certificate be executed the attending physician and ed for use as the burial - transitions and the second of the second o	dical															
68760, ertificate be ding physici	Med	IF FEMALE:		23c. If yes,	outcome or	pregnanc	,permi	2,691		-				d. Date of de		
certification of the certifica	Physician/Med	23b. Was decedent pregna past 12 months?		1 Live b	birth nant at time	of death		il death er <i>(Specit</i>	3 <u> </u> fy)	Ectopic	pregnanc	У		Month	Da	y Year
Box te death of the atter	hysi			9 Unkn								00- Bid			1-1-1	ne cause of death?
Records, P.O. Box 68760. The law requires that the death certificate b cate has been signed by the attending physicate has been signed by the attending physipage 2 should be detached for use as the bu	ð	Part II. Other significant	conditions of	ontributing to	o death but	not result	ing in the un	aeriying a	cause gi	iven in Par	τ ι.			_		ibly 4 Unknown
ords, w requires to been si should b	Completed											24a. Was				opsy findings available impletion of cause of
Ceco	omo											perf	ormed?		ath? Yes	2 No
tal Rec	Be	25. Was case referred to examiner?		spital:					1/	of Death (
of Vital Records ing Physician: The law required this certificate has been uneral director, page 2 should	2	1 Yes 2	No	28a. Date	of Injury		Outpatient Time of Inj			y at Work?		Home 5		ry occurred	Other:	
OD OP OP ath. or: Aft. he fune	tion	1 Natural 5	Pending	(Month	h, Day,Year)			· 1		es 2						
Division of Vital Records, ra lor Attending Physician: The law requir rs after death. 1al Director: After this certificate has been seled in by the funeral director, page 2 should	Certification	2 Accident 3 Suicide 6	Investigation Could not be determined	28e. Plac		At home,	farm, street	, factory, o	office bu	uilding, etc	. 2	Bf. Location or Town,		nd Number	or Rura	al Route Number, City
Division of Vital Bother the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,		4 Homicide 29a. Certifier 1 Certif	fying Physician	(Specify)		wledge, c	leath occurre	ed at the t	time, da	ite and plac	ce, and du	ue to the cau	ıse(s) an	d manner a	s state	d.
To the within 2 To the complet	Medical	one) 2 Medic		n the basis nd manner s		tion and/o	r investigatio				urred at t	he time, dat				
	Ž	29b Signature and title of	of certifier	201	0 1			1	O.C.N	number M.E.				Date signed vember 29		th, Day,Year) 10
		30. Name and address of	f person who cor							-						
5		Patricia Aronica-					miner		nn Str	reet, Bal	ltimore,	MD 212	01			
St Regis		31. Date filed (Month, Day	y, Year) 0 2010	32. R	egistrar's Si ال	grature	barke									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2010 Rache1 I. Schatz 6:23 Рм Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19 Bishops Lane Baltimore Catonsville Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Min MAR 28 217-18-9717 ∜922 **Director** Usual Residence of Decedent 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 1 🗌 Yes 2 💢 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Bishops Lane 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 □ Divorced Year or Dates artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Issac Bergdall Rebecca Dasher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Schatz, son 600 Hollow Road Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 12/23/10 Elkridge, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No 1 Yes 2 N 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No neral Director: A I filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month. Day, Year) 16354 December 20, 2010

Registrar DHMH 17 Rev 7/2009

State

8

Baltimore, MD

21229

900 S. Caton Avenue

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M, D.

Enser W. Cole,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 19, 2010 8:50 AM SANDERS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCHRIST HOSPICE TOWSON 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours Min. 1 X M 2 - F 09/29/1924 Director 251-24-4416 86 Usual Residence of Decedent 10a, State 10d. Inside City Limits 10b. County 10c. City. Town or Location **Funeral Director** 1 ▼ Yes 2 □ No BALTIMORE MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? USA 1613 EAST COLDSPRING LANE 21218 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Divorced BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION LABORER 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ MARTHA JACKSON HUBERT SANDERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN JONES/DAUGHTER 1613 E. COLDSPRING LANE BALTIMORE, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/28/2010 BALTIMORE, MD ON SITE CREMATORY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between and Death Immediate Cause (Final Physician/ Von disease or condition resulting in death) Medical Due to r as a consequence of) **Examiner** Shag Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Wiln that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Artery disease, congestion 2 14 No 3 Probably 4 I Unknown မ Certificate:

Hospital or Attending Physician: The law requires that the death certificate be Box 68760 Division of Vital Records, has To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral

or 28a-f shov

must be notified at

other traumatic event,

should be file h and Mental F 7 is marked o

Page 1 and 2 si ment of Health a

filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a-f sho

Baltimore, Maryland 21215-0036

210119		TE 163 ZE 140 GET TODADIY TE GITATOWN		
Heart faity Stroke re	re, Diabetes Mellitus Aul failure hypertension	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?		
25. Was case referred to medi al	26. Place of Death (Check	only one)		
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hol	ne 5 Residence 6 Sther (Specify) Hospice		
27. Manner of Death 1 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 Yes 2 No	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

25

Charles

205

3

State

Medical

29a. Certifie (Check

only one)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B

MC

29b. Signature and title of certifier

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ December 2010 8:45 P M Julia Ann Skelton Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Essex 1536 Doolittle Road 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In vrs. last birthday. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral Min. 1 □ M 2 🔯 F Hours 11/12/1917 Director 234-07-3865 93 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1536 Doolittle Road 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medicance. Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Manufacturer 8 Seamstress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Mary Elizabeth Atkins Elijah Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1536 Doolittle Road, Baltimore, Maryland 21221 Bernard Skelton (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Bayview Crematory, Inc. 12/23/2010 | Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Fline A Succine bicensee ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ungestive Heart Failure Physician/ disase or condition reulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit 2 ronge Due to (or as a consequence of) resulting in death) Last Physician/Medical pertension Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Unknown 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, Be 25 Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2× No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

V State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

hukwuma 31. Date filed (Month, Day, Year)

20

Name and address of person who completed cause of death (Item 23a) (Type, Print) hukwumu E50, 1124 Mace

82. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D61907

Avenue,

12/20

Baltimore MD 21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:58 PMM 2010 <u>Joseph</u> December Anthony Szczybor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>933 Lance Avenue</u> Baltimore If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Maryland 1**X** M 2 □ F Months Hours Min. (Month, Day, Year) 9/11/1923 Director 87 <u>215-18-5826</u> 10b. County 10a. State 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Tes 2X No **Essex** Maryland| Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21221 933 Lance Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?

117 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: 3 X Widowed 4 Divorced Completed Year or Dates White 1944 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Body and Fender Technician <u>Auto Body Repair</u> 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o traumatic Szczybor Pauline Wentland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Marll (Daughter) 914 Deer Court Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/2 2010 permit. Page Department of Important: If any injury or Sacred Heart of Mary Cem. 4 Donation 5 Other (Specify) Dundalk, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Fastern Avenue Essex, 50 Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line prostate Immediate Cause (Final metastatic cancer Physician/ year disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) **To the Hospital or Attending Physician**: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death been signed by the s should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 XN Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 XResidence 6 Other (Specify) Hospital: 1 🗌 Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated destroying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title

31. Date filed (Month, Day, Year)

f.certifie

acks

mo

32. Registrar's Signature

29c. License number

30. Name and address of person who combileted cause of death (Item 23a) (Type, Print)
Michelle Juaneta U.D. 301 Eastern Blud. Ste. B. Baltimore MD 21221

D0053641

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#4b, perPHS#10e, perFH, G910, 12/20/2010, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 7:50 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timo HOS Towson 100000 If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 1 ☑ M 2 ☐ F Months Davs Hours Director 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Funeral Director must be notified 28a-f 1 Yes 2 No mh 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Edgecombe 23a 21215 items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ō Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: "natural", 3 Widowed 4 Divorced ac 27 is marked other than "natur r traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) hoo Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Şurname) <u>ی</u> Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnson MD 21133 Department of Health Important: If item 27 any injury or other tronge. 20b. Place of Disposition (Na competery, crematory or 20a. Method of Disposition 20c. Location - Oity or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16-20 2. Name and Address of Facility Vaushn 21. Signature of Funeral Service Licensee BerVKES Road 23a. Part 1. Ent if the disease, or corv. lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stace End ATIOS months disease or condition Medical resulting in death) Due to (or as a conseq ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by bacterentia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown my cobacter in nin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cerebral mass certificate has birector, page 2 s autopsy performed 1 Yes 2 No 2 Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 XNo 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) (1557) € P ျ 1 Inpatient 2 ER/Outpatient 3 DOA this (28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0070635 12/10/16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel Christes 701 31. Date filed (Month, Day, DEC 2 32. Registrar's Sig State 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g910, 12/17/2010dhb

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year 32 Medical asan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month Day, Year) May 22, 1970 5. Social Security Number 039-44-7525 6. Sex 1 🖾 M 2 🗆 F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min 40 Gu<u>am</u> Director Usual Residence of Decedent 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director MD Glen Burnie Anne Arundel 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 Sumac Drive 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: White 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Parking Attendant Service Be 17. Father's Name (First, Middle, Last)

John E. Smith

20b. Place of Disposition (Name of

Final Journey Cram.

cemetery, crematory or other place)

Physician/ Medical Examiner

attending physician and for use as the burial-transit

signed by

s certificate has b director, page 2 s

this

or 28a-f shov

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at

ည

Baltimore, Maryland 21215-0036

Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

disease or condition

resulting in death)

ex

27. M

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

Janet Smith / Sister

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Live

23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final

1 Burial 2 Cremation 3 Removal from State

Po Box 1413, Baltimore, MD 2	21203
nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line.	Approximate Interval Between Onset and Death
a. Cardingenie Shock Due to (or as i consequence of):	Oliset and Deali
b. Coronary Artery Disease	15 min
c. Carchac Tampenarke Due to (or as a consequence of): CERTIFICATION APPROVED BY MICHINER CERTIFICATION APPROVED BY MICHINER	
d	
	L

18. Mother's Name (First, Middle, Maiden Surnar

Jeannette

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Devon Shire Dr., Aylett, VA 23009

Date

11/19/10

DeMille

20c. Location - City or Town, State

Woodbine, MD

23d. Date of delivery

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

2 No

Year

Month

23e. Did tobacco use contribute to the cause of death?

ш	resulting in death) Last	Due to (or as a consequence of):	
dical	•	d	CER
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	
d by Pr		s contributing to death but not resulting in the underlying cause	given in Part I.
Completed	- Terrial Co		
e Con	25. Was case referred to medical	26	S. Place of Death

xaminer

ŏ မှ within 24 hours after too...

To the Funeral Director. After this Certificate: Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

aminer? Yes 2	-No
anner of Death	
Natural	5 Pendi
Accident Accident	Invest

Investigation 6 Could not be determined

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

GREENZ

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 🗌 Yes

performed

2

24a Was an

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

(Check 2 Medical Examiner: On the basis of examination and/or investigation only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death		and place, and due to the cause(s) and manner stated
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

26. Place of Death (Check only one)

29d. Date signed (Month. Day. Year. 16-2011

3 Suicide 4 Homicide

29a. Certifier

31. Date filed (Month, Day,

32 Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 2 Month 1 I Day 2010 Miriam L. Stokes a M 3:05 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Towson Balto 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2 🕱 F Month Day, Year 1919 215-22-1912 91 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland rral", or items 23a or 28a-f sho Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director XXYes 2 No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 2936 E. Preston Street 21213 S IJ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. by 1 Never Married 2 Married "natural", or 21215-0036 72 hours after 1 ☐ Yes 2 XNo Specify: Black If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Counselor Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Manning Burns, Sr Lucinda Thompkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam M.Stokes 628 Villager Circle Dundalk, MD 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Σ Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Arbutus Memorial 12-20-2010 Arbutus, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H email 1101 Ε. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or se a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician afor use as the burial Physician/Medical MIRAM STORES Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 🗌 Yes ြု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) within 24 hours at er death.

To the Funeral D rector: After thi completed filled in by the fureral Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title o 29c. License number 29d. Date signed (Month. Day, Year) 2010 ress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dec. 1 7^y 20°f°0 Richard Ray Smith 10:25am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Woods Center Rossville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1**X** M 2 □ F 217-24-7604 86 March31,1927 PA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Baltimore Middle River Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Dogwood Drive 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify White 2 Specify: 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Millwright Western Electric 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Smith Bessie Schoat 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Seidel /daughter 426 Gilmor Road Joppa Md 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 12/18/10 Baltimore MD 4 □ Ponation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD of Funeral Tervice Cense 21. Sig Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIC ANCER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 Tyes 2 TNo 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DEMENTIA 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 25. Was case referred to medical examiner? 26. Place of Death Check only one) Be Other: 4 Narsing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

Physician /Medical Examiner

Funeral

Director

show

death with

72 hours after

should be filed within and Mental Hygiene.

d 2 should be find and Mental Find Tis marked off

permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is r any injury or other traur

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

burial-tran physician as the b use for ed by the a detached f P.O. signed by Records, need

Division or Vital

Physician:

or Attending

Hospital

page 2 certificate funeral director, After this ospitai c. 4 hours after deau. ~ral Director: Aftr within 24 hours at To the Funeral D

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE

30. Name and corress of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SQUARE DR. 9105 PARSHALL

31. Date filed (Month, Day, DEC 20

29b. Signature and title of certifier

4 Homicide

(Check only

29a. Certifier

32. Registrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

DHMH 17 Rev 1/2001

10-0962	6
Richard	Satterfield

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 100 9 amend #Istate of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate o	f Death	Reg	g. No.	
Physicia edical Exami	an/	Decedent's Name (First, Middle,Last)	2. Date of Death Month December		3. Time of Death 0530 hrs	
CUICAI EXAIIII	IIGI	Richard Satterfield 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	
*		2309 Homewood Avenue	Baltimore			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Days Hours Mir		(MM/DD/YYYY) 9. Birti , 1935 Foreign Cou	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local				10d. Inside City Limits
*	5	MD Baltime	ore			1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must he notified at once.	Director	10e. Street and Number 2309 Homewood Ave.	10f. Zip Code 21218		g. Citizen of What Coun	try?
	Funeral	1 Never Married 2 Married Armed Forces? If Yes 2 No	as Decedent of Hispanic Origin? (S res, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	
urs afte	ā	15. Decedent's Education (Specify only highest grade completed) 16a. Deceder	Yes 2 No specify: "It's Usual Occupation (Give kind of		Specify: Bla 16b. Kind of Business/Ir	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working life. DO NOT use ret		y	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	E O	11th Heavy 17. Father's Name (First, Middle, Last)	Machine Opera	e (First, Middle, M	Hydro-Co	nao
215 be filed ntal Hy rked o	Be	Major Satterfield		Rogers		
D 21 should and Me 7 is ma	욘		g Address (Street and Number or unsinane Dr. No			
e, MD I and 2 sho Health and Item 27 is	l	20a Method of Disposition 20h Place of Disposi	sition (Name of cemetery,		20c. Location - City or	Town, State
Baltimore, permit. Pages I are Department of Hes Important: If the Injury or other tr		1 Burial 2 Cremation 3 X Removal from State 1 Donation 5 Other Specify:	her place) Peace n Baptist De	c.27.20	10 Roxbor	27574 o.N.C
Salti cermit. Departm importa		21 Pro alure of Funeral Service Licensee	lame and Address of Eacility Scruge	gs Fune:	ral Home	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	412 E. Prestor	st. B	alto.Md.	21213 Approximate Interval
IMedical	ŀ	failure. List only one cause on each line. Immediate Cause (Final disease a. Inhalation of Smoke and Soot				Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of):				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mindated				
ing. de Ling	Exar	events resulting in death) Last Due to (or as a consequence of): d				
e execucian and	Medical	UNPENDED X AMENDED, per Fh g910	12/21/10 TT			
ffcate be g physici the buri		IF FEMALE: 23c. If yes, outcome of pregnancy		anov	23d. Date of delivery Month D	ay Year
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be executed. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	Physician	past 12 months?	tal death 3Ectopic pregnate	ancy	IVIORITY D.	ay 16al
O. Bat the dat the data the data the data the trached		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
S, P.O. uires that the signed by the detacl	ed by				2 No 3 Proba	
aw requas been 2 shoul	Completed			24a. Was ar autopsy perform	prior to co	opsy findings available ompletion of cause of
Rec : The liftcate l		or w	26 Place of Doobb (Cheek	1 ✓ Yes 2	No 1 ✓ Yes	2 No
/ital	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check 3 DOA Other Nursin		esidence 6 🗸 Other	Scene
Division of Vital Records, rat or Attending Physician: The law require rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	-1	27. Manner of Death 28a Date of Injury 28b. Time of I		28d. Describe ho Subject was i	w injury occurred n house fire	
Attender death rector:	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, stree	1 Yes 2 V No	28f. Location (St	reet and Number or Run	al Route Number, City
Div		3 Suicide 6 Could not be determined (Specify) Rowhome		or Town, Sta		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigal and manner stated.				
F 3 F 3	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
		1000 m	O.C.M.E.		December 14, 20	10
3		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111	Penn Street, Baltimore, M	D 21201		
Sta Regist	_	31. Date filed (Month, Day, Year) DEC 20 2010 32. Registrar's Signature August 2. Spark	,	OGM	E	

10-0	9622	2		
	-	_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Elnora R. Satterf		1- For State Registrar		of Waryland 7		ment of H		a Mental i		eg. No. 201	0 60092
Physicia Medical Examir		1. Decedent's Name Elnora	e (First, Middle,Las R. Sat	terfield	-				2. Date of Dea Month December	Day Year	3. Time of Death 0530 hrs
			if not institution, give	e street and number)			City, Town, or	Location of Dea		4c. County of Dea	eth
Funeral		5. Social Security N	lumber 6. Se	x 7. Age	(In yrs. last	birthday) I	f Under 1 Yea			rth(MM/DD/YYYY) 9. E	
Director	Director $243-68-8390$ $_{1\square M}$ $_{2\square F}$ 69 $_{Yrs.}$ $_{Months}$ $_{Days}$ $_{Hours}$ $_{Min.}$ $_{June 13,194}$ $_{1}^{For}$								country) N.C.		
any	ŀ	Usual Residence of 10a. State	f Decedent 10b. County		IOc. City, To	own or Location					10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ē	MD			Ва	ltimor					1 X Yes 2 No
the Mary 3a or 28a	Director	10e. Street and Nu	mewood 1	Ave.		10	of. Zip Code 212	18	1	0g. Citizen of What Co USA	untry?
fter death with ", or items 2.	y Funeral	11. Marital Status 1 Never Marrie 3 Widowed	ed 2 X Married	1 Yes 2 ≥ If Yes, Give Year	ver in U.S.	If Yes,		n, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - Am White, etc.	erican Indian, 8lack,
2 hour	Completed by	15. Decedent's Ed		College (1-4 or 5-2 yrs		6a. Decedent's l during most	of working life	tion (Give kind o . DO NOT use re		16b. Kind of Busines Kirk Av Day Car	enue
215-0036 be filed within 7 mtal Hygiene. riked other than cent, the Mellen	æ		Torain	-				Magg	ie Johr		
MD 21 d 2 should th and Me n 27 is ma numatic ev		-	tterfie.	ype, Print) Ld (daugh							te, Zip Code , Md . 21236
Baltimore, permit Pages I an Department of Hea Important: If ited		= .		Removal from Stat		ce of Disposition		ist	Date 27,20	20c. Location - City	21236
Balti permit Departi Importi			neral Service Lisen	500	1 0110	22. Nam Cal	e and Address Vin B	of Facility Scru	ggs Fur	neral Hom Balto,Md.	ie
Physician Medical			ly one cause on ea								Approximate Interval Between Onset and Death
Examiner	Immediate Cause (or condition resulting		Smoke Inhalation Due to (or as a consec							Deali	
	iner	Sequentially list confirming any, leading to improve cause. Enter Under	nmediate	Due to (or as a consec	quence of):						
and and -transit	I Examiner	(Discase or injury t events resulting in	events resulting in death) Last Due to (or as a consequence of): d								
O, e be exec	ledical	UNPENDED	X	AMENDED 20b, per	r Fh g	910 12/	21/10	TT			
Box 68760, e death certificate be the attending physic ed for use as the bur	sician/N	IF FEMALE: 23b. Was decedent past 12 months	pregnant in the	1 Live birth 4 Pregnant at ti		2 Fetal c		Ectopic preg	nancy	23d. Date of delive Month	ery Day Year
that the de ned by the detached i	by Phy	Part II. Other signi		contributing to death	but not resu	Ilting in the unde	erlying cause (given in Part I.		bbacco use contribute	to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteodiog Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Fuocral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Completed		-						24a. Was autop	an 24b. Were prior to death?	autopsy findings available o completion of cause of
Vital Rec ysicino: The his certificate director, page	Be C	25. Was case referrexaminer?		· · · · · · · · · · · · · · · · · · ·			26.Place	of Death (Chec		2 10 1	765 2 100
n of Vil diog Physic I. After this	위		2 No	lospital: 1 Inpatien 28a. Date of Injury		R/Outpatient 3		Other: Nurs		Residence 6 🗸 Oth	er: Scene
tion c treeding leath. tor: Af	ation	1 Natural 2 ✓ Accident	5 Pending Investigation	Dec 14, 2010	ar) 0	430 hrs	1	Yes 2 ✓ No		im of house fire	
Division ospital or Atteod hours after death neeral Director: y filled in by the	Certification:	3 Suicide 4 Homicide	6 Could not I				actory, office b	ouilding, etc.	or Town, S		Rural Route Number, City lore , MD
To the Hos within 24 h To the Fuo completely	Medical (29a. Certifier (Check only one) 2	Certifying Physici Medical Examiner	an: To the best of my ron the basis of exam and manner stated.	knowledge, ination and/	death occurred for investigation,	at the time, da	ate and place, ar n, death occurred	nd due to the caus dat the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	Σ	29b. Signature and	tifle of certifier				29c Licens O.C.			29d. Date signed (A) December 14,	
2 OCME	Ī	30. Name and addre Mary G. Rip	//	peripleted cause of de outy Chief Medica	,	•	enn Street	, Baltimore,	MD 21201	•	
Sta Registr		31. Date filed (Mont	/	72. Registrar	s Signature	back	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Minnette Month Day 30 3:58 PMM JOHOL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University of Maryland Baltimore Medical Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Country) Maryland 1 🗆 M 2 🕱 F Months Days Hours Min Director 218 42 1943 66 Usual Residence of Decedent th and Mental Hygiene. 27 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 🗌 Yes 2 🛚 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21085 75 Haverhill Road U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 11th Be permit. Page 1 and 2 should be file.
Department of Health and Mental Humportant: If then 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William J. Krauch Sr. Gertrude Isabelle Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Johns / sister 509 Vista Avenue Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/06/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 onna 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral ory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SCREWIS disease or condition resulting in death) PROF Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) PROVED BY MEDICAL EXAMINER been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION Physician/Medical of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year 1 ☐ Yes ∠ v 9 ☐ Unknown Unknown Part I<mark>I. Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by tailure COLOUOTA VESTIB 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s performed? Yes 2 this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After Natural 5 Pending Division 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after on Funeral Direct 4 Homicide determined Hospital edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signal 29c. License number

State Registrar

University

32. Registrar's Signature

2/201

Green

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Quarticció

0 3 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25,23aPtI, per me, 2910,12/17/2010dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Month Mary Toscano 2145 PM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Seasons Hospice Randallstown Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 1 □ M **XX**F Hours 218-58-3940 June 4, 1949 Mary land Director 61 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Carro11 Maryland Westminster 1 🗆 Yes 2XXNo 10e. Street and Number 0 10f. Zip Code 10g Citizen of What Country?
United States items 23a Funeral 530 Old Westminster Pike 21157 of America 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or à 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 7th Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Ostasewski Theresa Celano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose Toscano (Husband) 530 Old Westminster Pike, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. Date 12. Burial 2 Cremation 3 Removal from State Druid Ridge Cem. 2010 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Final Sepice Licens 11605 Reisterstown Rd., Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Intracerebral Hemorrhm Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Y MEDICAL EXAMINER The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) CERTIFICATION attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24a. Was an 24b. Were autopsy findings available has autonsv prior to completion of cause of death? this certificate 1 ☐ Yes 2 ☑ No Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 - Other Specify 1 X Yes 9 17 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 🗀 Yes 2 🗆 No 5 Pending iniury 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 🖳 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSKyapalnem.D 00057465 12/9/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209 Rajapakse, M. D. 2835 Smith M. S- 203, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ANGELA GLORIA TRUSKA 17:20 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL HOWARD HOWARD COUNTY GENERAL COLUMBIA COUNTY 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Days Hours Director 1931 **159-26-5540** Pennsylvania Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 8700 Ridge Road, 104 USA Apt. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No White Specify. Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ပ Philip Campise Marv Manzoni Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew S. Trusko, Husband 8700 Ridge Road, Apt. 104 Ellicott City, MD 21043 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 12/18/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licensee emation society Of Maryland, Inc. 9 Frederick Road Baltimore, Maryland 21228 Thomas Gregor romai 23a. Part 1. Enter the disease, or complifia ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the such as a cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final Onset and Death CONGESTIV HEART FAILURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SEVERE CARDOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury STAGE RENAL DISEASE END that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by VENOUS THROMBOSIS 1 Yes 2 No 3 Probably 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD Mytheles D0064760 Dec, 17, 2010

Registrar

MD, 10710 CHARTER DRIVE SUITE#310, COLUMBIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MYTHILY VANCHA.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 38 Ina Medical ecembe 4a. Facility Name (if not institution, give street and numbe, Examiner 4b. City, Town, or Location of Death 4c. County of Death 1 mo 8. Date of Birth (Month, Day, Year) Avgust 20 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Birtine Country) **Funeral** Days 1 M 2 KF Months Hours Yrs Director 216-32-2386 filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1

Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 1220 N. GILMOR STREET 21217 USA "natural", or iten fedical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Completed 3 Widowed 4 X Divorced Specify: BLACK Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the HEALTH other NIIRSE Be 17. Father's Name (First, Middle, Last) it. Page 1 and 2 should be filed rtment of Health and Mental Hy rtant: If item 27 is marked oti njury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ္ CLARENCE HADLEY MARY G. ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAVANNA HADLEY/SON 623 LINWOOD ST., BALTO., MD 21229 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) ON SITE CREMATION 12/23/2010 BALTIMORE, MD 22. Name and Address of Facility Signature of Funeral Service Licenses JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO. Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, ner Due to (or as a sunsequence of): if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events the attending physician and the for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death rate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page Yes 2 4 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16,2010 Physician/ December Thomas Thompson 7:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12 Cedar Cone Ct Balto. Nottingham nder 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 ፟ M 2 □ F Hours (Month, Day, January 346-32-2168 30,1940 fillinois Director 70 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🗓 No Nottingham Balto. Md. 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 or items 23a 12 Cedarcone Court I and 2 should be filed within 72 hours after death v F Health and Mental Hygiene. item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Race - Auron Black, White, etc. White þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Director of Business 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Laskowski Donald G. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Thompson Spouse Nottingham, Md. 21236 Cedarcone Court other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ott 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12-20,2010 Balto. Md. Bayview 21. Signature of Funeral Service Licensee Schimunek Funeral Home Nottingham, Md. 21236 22. Name and Address of Facility 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con Examiner Sequentially list conditions, Examiner day, leading to minediate cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month 1 Yes 2 No the is been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by yperlipide mig 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be P. 2 No Hospital: Other: 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manyler of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 602 Belair Rd: ise of death (Item) 1 inothy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Mary				/lental Hyg	giene	10	1.0000	
	1 - State Registrar Certificate of Death Reg. No U								40030		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Dea Month	Dav	Year	3. Time of Death 7:30 A M	
	Physician/ Medical Examiner William Scott Tabin 4a. Facility Name (if not institution, give street and number)					Location of Death	12	4c. County	3010	7.50 A M	
مبد) Examin	er	917 Mount Desert Harbour						ne Ar	undel	
100	Funeral		5. Social Security Number 6. Sex 7. Age (In s	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birth	place (State or Foreign	
	Director		216-76-2220 1 M 2 □ F	5 / Yrs.	Months Days	Hours Min.	(Month, Day,	1959	Was	hington D.C	
	nd how at	ž	Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Loc	cation				1	0d. Inside City Limits	
	faryla 8a-f s tified	Director	Maryland Anne Arundel	Pasadena						1 ☐ Yes 2X No	
	the N		10e. Street and Number	- ubadena	10f. Zip Code			10g. Citizen of	What Cour	itry?	
	n with 1s 23 nust b	Funeral	917 Mount Desert Harbour		21122	2		U.S	S.A.		
	death r iterr iner n		11. Marital Status 12. Was Decedent Ever in Armed Forces?			ispanic Origin? (Spe In, Mexican, Puerto			e - Americ		
39	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er tha Medical Examiner must be notified at , the Medical Examiner must be notified at	Completed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1	☐ Yes 2 🗓 No	Specify:		Specify.		ite	
9	hours natur lical I	lete	15. Decedent's Education		ent's Usual Occup			16b. Kind of B			
7	uin 72 be. han " e Mec	omp	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	ind of work done on NOT use retired)	during most of work	ing				
2	d with tygier ther t	e e	12 N/A	Gene	ral Conti	-				ruction, Ind	
Maryland 21215-0036	should be filed wit and Mental Hygie is marked other aumatic event, th	To B	17. Father's Name (First, Middle, Last) Charles F.	Tabés C	-	18. Mother's Nam			e)	D . 1	
Ž	should be file n and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)	Tobin, S:		Elizabet		B.	Stata Zin (Butler	
	12 sh alth ar 27 is ir trau	Ì	Christa L. Tobin (Wife)	1.		ert Harbo					
Jre,	of Heal of Heal fitem ;	a (20a. Method of Disposition 20	b. Place of Dispos			Date	20c. Location -			
<u>=</u>	Page ment o ant: If ury or		1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	-	Crematory		4/2010	Glen Bu	ırnie	. Maryland	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	M.	Name and Addres	ss of Facility Olyniak Fi Lain Road	meral H	ome P	Λ		
	0.07 = 40		John I Man	[3]	204 Mount	ain Road	Pasaden	a. Mary	Tand		
			23a. Pa.x. Enter the disease, or complications that caused the cshock, or heart failure. List only one cause on each line. Immediate Cause (Final				or respiratory arre	est,		Approximate Interval Between Onset and Death	
	Physician/) Medical	SK 5	disease or condition a. C'orm 2	y 21ter	y dise:	2se			-	Onset and Doddin	
	Examiner										
		iner	Sequentially list conditions, if any, leading to immediate cause Exter Indexiving. Due to (or as a conscious Exter Indexiving.	sequence of):	143					20 years	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										8 years	
	e execian a	alE	resulting in death) Last Due to grant as a cons	sequence of):						0	
760	death certificate be executed te attending physician and ed for use as the burial-transi	edical	d								
89	certific nding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre					23d Da	te of delive	Nr.v	
Box	eath e atte	icia	in the past 12 months? 1 ☐ Live Birth 2 ☐ 1 ☐ Ves 2 ☐ No 4 ☐ Pregnant at time		Ectopic pregnanc Other (specify)	у		Mo		Day Year	
		Phys	9 ☐ Unknown								
, P.O	gned oe d	þ	Part II. Other significant conditions contributing to death but not	resulting in the ur	iderlying cause giv	en in Part I.	23e. Did tot	/		e cause of death?	
Vital Records,	equire	Completed					1 1 1			ably 4 Unknown	
	law ha s e 2	mpl					24a. Was a autops perfori	sy F	Were autor prior to cor death?	ssy findings available npletion of cause of	
ř	n: The ficate h		25. Was case referred to medical		00 Di	ace of Death (Check	1 Tes		1 🗌 Yes	2 O No	
VITa	/sicia s cert	To Be	examiner?	☐ ER/Outpatient	Totha		1	anno 6 🗆 Otho	or (Spacific	12-141	
0	ng Phy ter thi		27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury work	at	28d. Describe ho				
0	tendir eath. or: Af the ful	ifica	1 Natural 5 Pending (Month, Day, Year 2 Accident Investigation 3 Suicide 6 Could not be	,,,		Yes 2 No					
Division of	or Att	Certificate:	4 Homicide determined 28e. Place of Injury - A building, etc. (Spe		et, factory, office		28f. Location (St. City or Town		er or Rural	Route Number,	
	spital iours a ieral [cal	29a. Certifier 1 Certifying Physician: To the best of my kr	lowledge death or	ccured at the time	date and place, an	d due to the caus	se(s) and manne	er as state	1	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director After this certificate completed filled in by the funeral director, pag	Medical	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of	ation and/or investi	gation, in my opinio	n, death occurred at	the time, date an	d place, and due	e to the cau	se(s) and manner stated.	
	vithi 70 th	٦	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed	(Month, L	Day, Year)	
			Seter Som MD		DS	56977		12/13	120	10	
_			30. Name and address of person who completed cause of death (C 1 1	11 = 4.	10 4	1		
	Stat	2			ite 201,	Garbari	113,14	0 210	057		
	Registra	r	31. Date filed (Month, Day, Year) DEC 2 0 2010	1. back	1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 213-36-186 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1802 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 No 2 □ No Funeral Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number items 23a Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 6 þ 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. lerica 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Be Brock ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee and Address of Facility MO Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** NOT /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physiclan; The law requires that the death certificate be executed can Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dialetu 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check onl- one Be Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No Hospital: 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident death. Director: A d in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a

To the Funeral D

completely filled Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Srivet 600 North Wolfe St, Baltimore, MD, 21287 van San 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year 05 FM ANNA IRENE WISNIEWSKI 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Franklin Square 5. Social Security Number 6. Sex osedale 1405 timore oi ta 8. Date of Birth (Month, Day, Year) 08 / 18 / 1919 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 1 ☐ M 2 🔀 F 91 Months Days Hours Min. PENNSYLVANIA 204 18 1013 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 ∐ Yes 2 🔀 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 1234 NARCISSUS AVENUE 21237 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2X ☐ No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RECEIVING CLERK DOXIE FOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT DUNMOYER **ESTHER** WEISE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY WISNIEWSKI/DAUGHTER 1234 NARCISSUS AVE BALTIMORE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MORELAND MEMORIAL 12/20/10 BALTIMORE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Uncertains Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

Examiner Division of Vital Records, P.O. Box 68760, Ξ or Attending Physician: The law requires that the death certificate be attending the peen has certificate this After

the use ę director, page 2 should o the Hospital or Attendithin 24 hours after death the Funeral Director; A completely

Physician

Examiner

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Experient must be notified at

Hygiene.

1 and 2 should be Health and Mental

Pages '

7 is marked other traumatic event, II

Department of Health a Important; If item 27 is any injury or other trai once.

Physician

/Medical

21215-0036

Maryland

Baltimore,

53

Director

Funeral

<u>ک</u>

Completed

Be

ပ

Examine

Physician/Medical

ş

Completed

Be

Certification: To

Medical

4 Homicide

(Check only one)

29b. Signature and title of dertifier

29a. Certifier

/Medical

State

within 7

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2d 9000 Franklin Squale Kirman, Mar, Year) Drive 31. Date filed (Month, Day, 20 2010

156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G910 12/20/10 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09:10 PM Vecember Burl (nmn) Wagner 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Elkton** <u>Abby Manor Assisted Living</u> Ceci] 7. Age (In yrs. last birthday) Social Security Numbe 6. Sex 1 A 2 D F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Country)
Maryland Months Davs Hours Min 218-14-2271 Director 89 Sep. Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Cecil **Elkton** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 58 Woods Way 21921 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black. White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 TNo Specify. Specify: Completed 3 Nidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Ice Cream Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Etta Elizabeth Greene Hade Sherrill Wagner other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris H. Grafton/Daughter 2256 Conowingo Road, Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 12-16-10 Bel Air, Maryland 21. Sjonal r uneral ervice McComas funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final AtherosCleone Carlibrasiale Diseace Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any hearing to immediate cause. Enter Underlying Examine Due to for as a conse, uence of To the Hospital or Attending Physician: he law equires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 teen signed by the attending parould be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ➡No Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has age 2 autopsy perform After this certificate 1 🗌 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? assisted Hospital Other: 4 Nursing Home Sesidence Control (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural
2 Accident
3 Suicide
4 Homicide work?
1 Yes 2 No 5 Pending injury f hours after death. uneral Director; Aft Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29b. Signature and title of certifie 29c. License number 34053 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34 Aviathon Blud 6 lea bu-nie MD 21061 MD bach 31. Date filed (Month, 32. Registra s Signature State

Registrar

			Please	• .			ont of Weelth and	-	•	e.	
		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1 0 4 0 1									
			Registrar 1. Decedent's Name (First, Middle, La	st)		Joranio	ate or Beatin	2. Date of Dea	Reg. No	3. Time of Death	
	Physicia Medio		WILBUR	LEON	WEBB	JR.		DECEMBI	ER Î7, 2ďÎ	1	
Examir			4a. Facility Name (if not institution, giv HART HERTTAGE	e street and number)			ity, Town, or Location of Death DREST HILL	1	eath		
	Funeral Director 5. Social Security Number 213-32-1776 6. Sex 1 🖾 M 2 🗆 F 7. Age (In yrs. last birth					Month	der 1 Year If Under 24 Hrs. ns Days Hours Min.	8. Date of Birt (Month, Da Feb 1	irth 9. Birthplace (State or Foreign New Jersey		
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Limits	
	Maryla :8a-f s tiffed	rect	Maryland Harfo	rd	Fores	t Hill				1 🗆 Yes 2 🔀 No	
	h the	Funeral Director	10e. Street and Number			10f.	Zip Code		10g. Citizen of What	Country?	
	ms 2%	ner	1699 Walters Mi	LL Road 12. Was Decedent I	Ever in II S	13 Was De	21050 cedent of Hispanic Origin? (Sp	posify You or No-	USA		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	No	If Yes, s	pecify Cuban, Mexican, Puerto s 2 X No Specify:	Rican, etc.)	14. Hace - Ar Black, W Specify: W		
5-0	2 hou "natu edical	plet	15. Decedent's (Specify only highest g		(0	Give kind of	sual Occupation work done during most of wor	king	16b. Kind of Busine	ss Industry	
12	vithin 7 iene. r than the M	Con	Elementary/Seconday (0-12)	College (1-4 or 5)+) "	fe. <i>DO NOT</i> E lect i	^{use retired)} Cical Engineer		Environme	ntal Research	
b	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)			<u></u>		_	Maiden Surname)		
ylaı	Menta	잍	Wilbur Leon Web				Marjor	ie Jane	Tinker		
, Maryland	id 2 shou ealth and n 27 is m er traum		19a. Informant's Name/Relationship (Clara R. Webb	,			ess (Street and Number or Ru Cers Mill Road				
Baltimore,	Page 1 ar		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Gather (Spec	Removal from State	20b. Place of D cemetery, Hillto	crematory of	Name of or other place) vice Corp. 12/2	Date 0/2010	20c. Location - City Towson,	or Town, State Maryland	
Balti	permit. F Departπ Importa any inju once,		21. Signature of Funeral Service Licer		#	22. Name		icComas I	Funeral Ho	me, P.A.	
			23a. Par 1. Enter the disease, or con shock, or heart failure. List only			enter the m	ode of dying, such as cardiac			Approximate	
	Physician/		Immediate Cause (Final disease or condition	ENL	Stasi	2 72	ement.s			Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as	a consequence of)						
00	- =	iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of)	:					
20	be executed sician and burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequence of)	:					
0	be ex sician burial	g		■ d	, ,						
68760	ificate ig phy as the	Medi	IF FEMALE:	- u							
. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the templeted filled in by the funeral director, page 2 should be detached for use as the templeted filled in by the funeral director.	Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death	3			23d. Date of Month	delivery Day Year	
s, P.O.	ires that the signed by die detail	d by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlyir	ng cause given in Part I.			to the cause of death? Probably 4 Unknown	
Records,	v requ	olete						24a. Was	an 24b. Were	autopsy findings available	
Rec	The lay	mo.						autor perfo	rmed? / death	o completion of cause of ? /es 2 No	
ta	cian; ertific	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death (Che			pssisted	
of Vital	Physician: T r this certifica real director, p	2	1 Yes 2 No	1 Inpati	ent 2 ER/Outp		DOA Other: 4 Nursing H		dence 6 Other (Sp low injury occurred	ecify) CARE	
on o	anding sath. nr. After	ficate	1 Natural 5 Pending 2 Accident Investigation		<i>i, Year)</i> inju	ıry M	work? 1 ☐ Yes 2 ☐ No	Log. Bosonbo	ow injury occurred		
Division	al or Atters a after de al Directo	l Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ury - At home, farm c. (Specify)	, street, fact	tory, office	28f. Location (S City or Tow	Street and Number or I rn, State)	Rural Route Number,	
	he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2 Medical Evan	iner On the hasis of a	vamination and/or i	nvestigation	at the time, date and place, a in my opinion, death occurred	at the time date a	nd place, and due to th	o cause(s) and manner stated	
	To the To the Com		29b. Signature and title of certifier	ature and title of certifier And And And And And And And And And And						nth, Day, Year)	
	10		30. Name and address of person who	completed cause of d	eath (Item 23a) (Ty	pe, Print)	PHAIL RU	I AM	MA 210	14	
i	Stat Registra	e ir	31. Date filed (Month, Day, Year)	32. Regis	r's Sixterya Ka	1					

10-096	524
Amari	Windley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of 1- For State Registrar	Maryland / Depar Cert	tment of F ificate of D		Mental F	-	g, No. 2010	40103	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Amari W	2. Date of Death Month Day Year December 14, 2010		3. Time of Death 0530 hrs					
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2309 Homewood Avenue 4c. County of Death Baltimore								
Funeral Director	5. Social Security Number 6. Sex 212-61-5461 1 M	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	ff Under 24Hr Hours Min	n.	h(MM/DD/YYYY) 9. B Fore 7,2001		
any	Usual Residence of Decedent 10a. State 10b. County		Town or Location			1	.,2001	10d. Inside City Limits	
yland t-f show t onec.	MD 10e, Street and Number	Bal	timore.	Of. Zip Code		110	ng. Citizen of What Co	1 X Yes 2 No	
the Maryland is or 28a-f sh utified at once	2309 Homewood A	Ave.		2121	8	'	USA	unity:	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married	. Was Decedent Ever in U.S Armed Forces? Yes 2 No es, Give Year	If.Yes	Decedent of Hispa specify Cuban, I es 2 X No	Mexican, Puert	Specify Yes or No- o Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,	
5-0036 led within 72 hours aft tygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only h Elementary/Secondary (0-12) 4 th	college (1-4 or 5+)	during most	Usual Occupation of working life. E			16b. Kind of Business		
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than numatic event, the Medies To Be Comple	17. Father's Name (First, Middle, Last) William Windle	7				e (First, Middle, M	Maiden Surname)		
MD 21: d 2 should the and Men a 27 is mar- numatic eve	19a Informant's Name/Relationship (Type, Mary Satterfield	l (grandmot	her) 2	Dunsir	nane D	r.AptI	ber, City or Town, Sta 21236 Nottingh	nam, Md.	
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra	20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other Specify:	Removal from State Du	ace of Disposition ematory or other laney	n (Name of ceme place) Valley	Cem De	Date C . 22 , 20	$^{20c. ext{Location} ext{-} ext{City} ext{c}}$	or Town, State	
	21 Signal Toyl Funeral Service Licensee	7	22. Nan Ca 1 141	ne and Address o Vin B. 2 <u>E. Pr</u>	Scrug	gs Fune St. Ba	eral Home	21213	
21 Symmon of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Hom 1412 F. Preston St. Balto, Md. Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):					est, snock, or neart	Approximate Interval Between Onset and Death			
er	Sequentially list conditions, b	to (or as a consequence of):							
feed ansit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due	to (or as a consequence of):	:						
be executed sician and urial - transit		MENDED							
Se ph at Q	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 9	3c. If yes, outcome of pregnation Live birth Pregnant at time of deat Unknown	2 Fetal	death 3 (Specify)	Ectopic pregr	ancy	23d. Date of delive Month	ery Day Year	
P.O. Es that the cymed by the detached by the by the detached by the by the by the by Ph	Part II. Other significant conditions con	tributing to death but not res	sulting in the und	erlying cause giv	en in Part I.		bacco use contribute t	o the cause of death?	
Division of Vital Records, P.C. To the Hospitat or Attending Physician: The law requires that within 24 hours after death. To the Fineral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be detailed and Certification: To Be Completed by						24a. Was a autop perfor	an 24b. Were a prior to med? death?	autopsy findings available completion of cause of	
ical Resident The certifica	25. Was case referred to medical examiner?	-			f Death (Check	only one)			
n of Vit ing Physic After this funeral direction.	examiner? 1 Yes 2 No 27. Manner of Death	28a Date of Injury	ER/Outpatient 3 28b. Time of Inju		ther Nurs	28d. Describe I	Residence 6 🗹 Oth	er: Scene	
Division o spiral or Attending nours after death or and birector: After filled in by the fune Certification:	1 Natural 5 Pending 2 ✓ Accident Investigation	Dec 14, 2010	0430 hrs		es 2 V No		m of house fire	Rural Route Number, City	
Divi	3 Suicide 6 Could not be determined	(Specify) Single Fami				or Town, S			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director. completely filled in by the	one) 2 Medical Examiner: On	To the best of my knowledge the basis of examination and manner stated.		ı, in my opinion, o	death occurred				
N X	29b. Signature and title of certifier			29c, License O.C.M			29d. Date signed (M December 14, 2		
OCME	30. Name and address of person who comp Mary G. Ripple MD. Deputy	oleted cause of death (Item 2 Chief Medical Exam		Penn Street,	Baltimore, I	MD 21201	<u> </u>		
State Registrar	31. Date filed (Month, Day, Year) DEC 2 0 2010	02, Registrar's Signature	bare	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Raymond F. Yost 18 20ÎT 3:13 AΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7314 Waldman Avenue Baltimore Sparrows Point Social Security Number er 1 Year If Under 24 Hrs. . Age (In yrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F DEC 2. 1940 Months Hours Min. Director 217-38-3887 Maryland 70 Usual Residence of Decedent 23a or 28a-f shov 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-s shoutrammatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Sparrows Point 1 🗆 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7314 Waldman Avenue 21219 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Trouble Shooter Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Edward Jacob Yost He1en Catherine Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Mary A. Yost, wife 7314 Waldman Avenue Sparrows Point, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/18/10 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George MacNabb Cremation Society of MD, sless 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final et py Physician/ metastan disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year the g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an i 24 hours after death. e Funeral Director: After this certificate has l performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only o 29b. Signature and December 18, 2010

10

State Registrar

DHMH 17 Rev 7/2009

OsIer

7505

32. Registrar's Signature

/pe, Print)

Dr

Suite 302

Towson, MD 21204

30. Name and address of person who completed cause of death (Item 28a)

M.D

Richard L. Huslig,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11/28/2010 Physician/ Ivan Julius Andrasik 3:40amM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1336 Chapelview Drive Odenton Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days XXM 2 D F Months Hours Min Czechoslovakia 223-80-3170 72 Director Usual Residence of Decedent or 28a-f shov 10b County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director MD Anne Arundel 1 Yes 2xXNo Odenton 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a Funeral 1336 Chapelview Drive 21113 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2X No If Yes, Give Year or Dates. Black, White, etc. ō þ 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify Specify: White "natural", 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Chemist Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I rtant: If item 27 is marked o ည Julius Andrasik Margaret Fedak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Andrasik 336 Chapelview Drive Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 Durial & Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 12/1/2010 Glen Burnie, MD 21. Signature of Funeral Services Consee 22. Name and Address of FacilityHardesty Funeral Home, P.A. Annapolis RD Gambrills 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Ponset and Death Immediate Cause (Final oncer - Non Sma Physician/ disease or condition resulting in death) Medical Due to (or as consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Dav Year the 9 Unknown þ been signed the should be detected Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?
Yes 2 No certificate 25. Was case referred to medica filled in by the funeral director, æ 26. Place of Death (Check only one) examiner? Other: 2 🗷 No မ 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA after death. 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral C 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature

State Registrar Glan

Burne

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr

32. Registrar's Signature

MOSPITAL

05

Plysician Power Marting 2 The Control of Section 1	0-09158 obert Agranov		Please Typ St	pe or Print in B tate of Maryland	lack ind	delible li	n <mark>k. E</mark> r f Healt	n <mark>sure A</mark> h and N	All Copie Mental H	es Are Leg lygiene	gible.	2010	1.0106
County C			l- For State Registrar							Re 2. Date of Deat	h	4 U I W	3. Time of Death
Ballimore Washington Medical Center Clan Burne Special Sp										Month November	Day 29, 20	Year 010	0351 hrs
Out Tested Committee Tested T									· ·				
The street and Number of Total Country The street and Number of Total Country The street and Number of Total Country Total Street and Number of Number of Number Number of Numb							Months			_		Co	rthplace (State or Foreign buntry) onnecticut
To See Order to Program of See	<u>*</u> ,	_	10a, State 10b. County				ion						10d. Inside City Limits 1 Yes 2 X No
19 19 19 19 19 19 19 19	the Maryla n or 28a-f	Directo		graph Road						10	-		intry?
Surviva 2			1 Never Married 2 M	Armed Forces	? 2 No	If Y	es, specify	Cuban, Me	exican, Puerto			White, etc.	
Surviva 2	\$6 n 72 hours aft nan "natural" ical Examine		15. Decedent's Education (Spe	ecify only highest grade co College (1-4 or	empleted)	16a. Deceder during m	nt's Usual (Occupation king life, DC					
Surviva 2	-003 withing grene.	E .	17 Father's Name (First, Middle	e. Last)				18.1	Nother's Nam	e (First, Middle, N	Maiden S	umame)	
Surviva 2	215- e filed tal Hy ked of									Schimerling			
Surviva 2	AD 21; 2 should b n and Men 27 is mar matic eve		19a. Informant's Name/Relations	ship (Type, Print)							vill	e, MD	21108
Physician failure. List only one cause on each line. 23a. Part I. Entité, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part I. Entité, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part I. Entité, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part I. Entité, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part I. Entité, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part II. Stite (the disease) 25a. Part II. Stite (the disease) 25a. Part II. Stite (the disease) 25a. Part II. Stite (the disease) 25a. Part II. Stite (the disease) 25a. Part II. Stite (the disease) 25a. Date of flexible or as a consequence of): 25b. Was case referred to medical examiner of death but not resulting in the underlying cause given in Part I. 25a. Date of death or the cause of the	nore, Nages 1 and at of Health t: If item other trau	l	1 X Burial 2 Cremation		tata a	ematory or ot	her place)		7ON	ember 30 2010	20c. Lo		
Physician failure. List only one cause on each line. 23a. Part I. Entité, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part I. Entité, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part I. Entité, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part I. Entité, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part I. Entité, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a. Part II. Stite (the disease) 25a. Part II. Stite (the disease) 25a. Part II. Stite (the disease) 25a. Part II. Stite (the disease) 25a. Part II. Stite (the disease) 25a. Part II. Stite (the disease) 25a. Date of flexible or as a consequence of): 25b. Was case referred to medical examiner of death but not resulting in the underlying cause given in Part I. 25a. Date of death or the cause of the	altin mit. Pa panmei portan jury or	1				33a	Yame and	Address of	jons, i	A. Seve	erna	Park F	uneral Home
Table 1. List only one cause on each line. The sequentially is cause final disease. Enter Underlying Cause immediate cause. Enter Underlying Cause (Disease or input) that initiated events resulting in death) Least of the sequential place or input that initiated events resulting in death) Least of the sequential place or input that initiated events resulting in death) Least or input that initiated events resulting in death) Least or input that initiated events resulting in death) Least or input that initiated events resulting in death) Least or input that initiated events resulting in death) Least or input that initiated events resulting in death) Least or input that initiated events resulting in death) Least or input that initiated events resulting in death) Least or input that initiated events resulting in death) Least or input that initiated events resulting in death) Least or input that initiated events resulting in death but not resulting in the underlying cause given in Part I. Least or input that initiated events resulting in the underlying cause given in Part I. Least or input that initiated events resulting in the underlying cause given in Part I. Least or input that initiated events resulting in the underlying cause given in Part I. Least or input that initiated events resulting in the underlying cause given in Part I. Least or input that initiated events resulting in the underlying cause given in Part I. Least or input that initiated events resulting in the underlying cause given in Part I. Least or input that initiated events resulting in the underlying cause given in Part I. Least or input that initiated events resulting in the underlying cause given in Part I. Least or input that initiated events resulting in the underlying cause given in Part I. Least or input that initiated events resulting in the underlying cause given in Part I. Least or input that initiated events resulting in the underlying cause given in Part I. Least or input that or input that initiated events resu			23a Part I Enter the disease or	or complications that cause	d the death.								MD 21146 Approximate Interval
Sequentially list conditions, fray, leading a minediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last Sequentially list conditions, fray, leading to minediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last June 10	* !Medical	failure. List only one cause on each line. Immediate Cause (Final disease a, Hypertensive Atherosclerotic Cardiovascular Disease complicated by Chest Injuries							Between Onset and Death				
Course Enter Underlying Cause (Display of the properties of the p				b									
The composition of the composi		niner	cause. Enter Underlying Cause		Soquence Ut)								
UNPENDED MAINING Mai	cuted nd rransit				sequence of)	:							
Progressive Supranuclear Palsy Progressive Supranuclear Palsy	at -	dica	UNPENDED	AMENDED									
Progressive Supranuclear Palsy Progressive Supranuclear Palsy	Sox 6876(leath certificate e attending phys for use as the b	/sician/Me	3b. Was decedent pregnant in the past 12 months?	the 1 Live birth 4 Pregnant a		2 Fe			Ectopic pregn	ancy			
29b. Signature and title of certifier 29c. License number O.C.M.E. November 29, 2010 At At Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	P.O. Es that the canada by the edetached				ath but not re	sulting in the t	underlying	cause give	n in Part I.				
29b. Signature and title of certifier 29c. License number O.C.M.E. November 29, 2010 At At Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ecords, he law require ate has been si age 2 should b	ompleted						_		autop perfo	osy rm <u>ed</u> ?	prior to death?	completion of cause of
29b. Signature and title of certifier 29c. License number O.C.M.E. November 29, 2010 At At Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	al R ian: T certific ctor, p							I Oth					
29b. Signature and title of certifier 29c. License number O.C.M.E. November 29, 2010 At At Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	F Vit		1 ✓ Yes 2 No										er:
29b. Signature and title of certifier 29c. License number O.C.M.E. November 29, 2010 At At Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ion o' trending leath. for: Afte	ation:											
29b. Signature and title of certifier 29c. License number O.C.M.E. November 29, 2010 At At Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Divis pital or A ours after eral Direc	Sertific	3 Suicide 6 Could not be determined (Specify) Personal care home 7548 Old Telegraph Road, Hanover, 1								er, MD		
29b. Signature and title of certifier O.C.M.E. November 29, 2010 At At At Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	o the Hos ithin 24 ho o the Fun		t	aminer: On the basis of ex	amination an	e, death occu d/or investiga	ition, in my	opinion, de	eath occurred	d due to the caus at the time, date	and plac	e, and due to t	he cause(s)
30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	E 3 E 8	Me	29b. Signature and title of certific										
Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			30 Name and address of person	on who completed cause of	death (Item	23a)					1		
State Registrar DEC 0 3 2010 32. Registrar's Signature A Saule	146 H			The same of the sa			111 P	enn Stree	et, Baltimo	ore, MD 2120	1		
T T T T T T T T T T T T T T T T T T T			31. Date filed (Month, Day, Year)	3 2010 32. Registr		B. 1	ark	/					

DHMH 17 Rev 1/2001 OCME 2006

ULINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Alice Astegher <u>DECEMBE</u>R 2010 9:00P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Reeders Memorial Home Boonsboro 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Dec. 8, 1917 Social Security Numbe 7. Age (In vrs. last birthday **Funeral** Min. Hours 109-18-8130 New York 92 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director notified Maryland Washington County Hagerstown 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a or the Medical Examiner must be Funeral U.S.A. 21740 17903 Hickory Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11, Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Stock Market Clerk is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Delia Geraughty Murphy Edward Murphy 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. 17903 Hickory Lane Hagerstown, MD 21740 John Astegher-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Smithsburg Crematory 12-7-2010 Smithsburg, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Lice Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do no, inter the mode of dying, such as cardiac or respiratory arrest Approx...
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Luc to (or as a consequence cry. attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year nts certificate has been signed by the atter director, page 2 should be detached for Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 WN 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tyes No No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) : After this c 28a. Date of injury (Month, Day, Year) . Manper of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 2 Accident 5 Pending Investigation within 24 hours after death

To the Funeral Director; 4
completed filled in by the f 6 Could not be 3 ☐ Suicide 4 ☐ Homicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year, 000632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

580 NORTHERN AVENUE

32. Registrar's Signature

SHAHID MAHMOOD,

31. Date filed (Month, Day, Year)

HAGERSTOWN, MARYLAND 21742

301-733**-**4496

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Day Physician/ 20°1°0 11:55 am Emma Elizabeth Arnie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester 507 West Appleby Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 26,1925 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🕱 F Maryland 220-16-7665 85 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits hours after death with the Maryland Director MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 507 West Appleby Avenue 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11. Marital Status Armed Forces þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) shirt presser garment 12 should be filed with lith and Mental Hygien 27 is marked other tl r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Lester Q. Thomas Netha Moore permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Elzev 504 Bayly Road, Cambridge, MD daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Dorchester Mem. Park 12/6/10 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) 05 W. Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? certificate 1 ☐ Yes 2 🖾 No 1 Yes 2 No 25. Was case referred to medical rector, Be 26. Place of Death (Check only one) examiner? Hospital: 2 XNo 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State Hospital Medical 29a. Certifier 🔭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC 06 2010

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ Mae 2010 Bertha Akers 6:05 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cambridge Dorchester Mallard Bay Care Center . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Days Hours (Month, Day, Year 929 North Carolina Director 232-58-3518 81 Usual Residence of Decedent shov 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Dorchester Cambridge and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4734 Egypt Road 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) admissions supervisor hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mack Coffey Esther McCroskev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vencil G. Akers husband 4734 Egypt Road, Cambridge, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem! 12/2/10 Hurlock, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licenses -K. 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner cetive sentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Dav Pregnant at time of death the Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 2 2 Ne 1 Tes Yes 2 6 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 2 🗀 No 1 Tyes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) e roc... n 24 hours after deaun. he Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Watural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

BYEN

57

503

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THANWY

DEC 0.2 2010

NOMAN

31. Date filed (Month, Day, Year)

47924

CAMBRIDGE

12.1.10

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For	Plea	se Type o			d / Depa	artment o	of H	ealth			-		gible.		110
Physicia	in/	State Registrar 1. Decedent's Name	e (First, Middle	,		D.C.O.T.		tificate o		eath		Mon	of Death th	Day	Year		e of Death
Medic Examin	cal	4a. Facility Name (if	not institution	VIRGIN , give street and nu		MAF	E AN	GLEBERO 4b. City, Tow		Location	of Death	Dec	embe	4c. Coun		th	85 <u>A</u> M
Funeral		Frederi 5. Social Security No. 219–44–25	umber	orial Hos 6.Sex 1□M25		e (In yrs. la	st birthday)	Fred If Under 1 Y Months D		ick If Under Hours	r 24 Hrs.	8. Date	of Birth	Fre 1946	deri 9. Bir	ck thplace (State ountry) yland	e or Foreign
Director		Usual Residence of 10a. State				64	Yrs.	oation				Jan	17,	1946_	Mar		City Limits
Marylan 28a-f sh otified a	Director	Maryland	Carro	11			n Bri	dge								1 🗷	Yes 2 No
n with the is 23a or nust be r	Funeral D	10e. Street and Nun 423 Qua		11 Road				10f. Zip Co 217				10g. Citizen of What Cou USA			ountry?		
s after death ral", or item Examiner n	To Be Completed by Fur	11. Marital Status 1 Never Marri 3 Widowed		16 Va a C	orces? 2 2			Was Decedent f Yes, specify (Cuban	, Mexica	n, Puerto	pecify Yes or No- b Rican, etc.) 14. Race - A Black, W Specify:			ack, Whit	erican Indian, e, etc. white	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		(Spe	cify only high	nt's Education est grade complete College		+)	(Give life. D	dent's Usual O kind of work do O NOT use ret dry wol	one du ired)	ing mos	st of work	ing	1	6b. Kind of		usiness Industry	
d be filed w Mental Hygi arked other ttic event, t		17. Father's Name (i				18. Mother's Name Lillie St					ne (First, Middle, Maiden Surname)						
ind 2 should lealth and N im 27 is ma her trauma			gleber	hip (Type, Print) ger – hus	sban		423	ng Address (St Quaker	Hi		oad,	Unio	on Br	idge,	Mar	y1and	21791
t. Page 1 a tment of H rtant: If ite ijury or otl		4 Donation	Cremation 5 Cher (5		m State	CE	emetery, crer auffer	osition (Name of matory or other Cremat	place	У	12-	Date 8-20	lo I	reder	ick,	Mary1	
Physician/ Medical Examiner	,	22. Name and Address of Facility Stauffer Funeral 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):															nate Between
executed an and rial-transit	dical Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated event resulting in death) I	nmediate rlying iinjury s	с		is a consequence of): is a consequence of):											
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death to the state death of the attending physici to the tuneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 t 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		2 Fetal	of pregnancy 2 ☐ Fetal death 3 ☐ Ectopic pregnancy time of death 5 ☐ Other (specify)						23d. Date of delive			elivery Day	Year	
v requires that the state of th	þ	Part II. Other significant conditions commoding to death purnot resulting in the andenying cause given in fact.										_					
The law req ate has bee page 2 sho	Completed									a. Was an autopsy perform		prior to death?	utopsy finding completion c				
Physician: The lar this certificate ha ral director, page ?	Be	25. Was case referrence examiner?	_/	Hospital:		- 0 D	FD/O-1		6. Pla Other	r.	ath (Chec				l /D	- 16 1	
nding Phys th. : After this s funeral di	cate: To	27. Manner of Death		28a. Dat (Mo		ry	28b. Time of injury	200.	Injury work?	at				nce 6 🗌 Ot v injury occu		cify)	
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Il Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could detern	not be 28e. Plac		iry - At hoi c. (Specify)		eet, factory, of	fice				ation (Stre or Town,		ber or Ru	ural Route Nu	mber,
he Hospit in 24 hour he Funera ipleted filk	Medical	(Check 2	2 🔲 Medical I	Physician: To the Examiner: On the b Nurse Practione	asis of e	xamination	and/or inves	tigation, in my	opinior	n, death d	occurred a	t the time	, date and	place, and c	lue to the	cause(s) and	manner stated
vith Vith To t		29b. Signature and	title of certifie	1-	05	pital	Rt	29c. Lid	cense	number	-13	5	29	d. Date sign	ed (Mont	th, Day, Year)	
6		30. Name and addr	ess of person	who completed call	use of de	eath (Item	23a) (Type, F	Print) Wile 1	Ø h.	MONE	1 11/ps	Sola	(
Sta		31. Date filed (Mont	th, Day, Year)	Q 2010	Registra	ar's Signat	ure	harke	1	/	,	+					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lucille Anderson	1- For State Registrar	tate of Maryland /	Department of Certificate of		id Mental H		2010 j. No.	
Physician/ Medical Examiner	1. Decedent's Name (First, Mid-	Rita Anderson				2. Date of Death Month December		3. Time of Death 0625 hrs
Medical Examine	4a. Facility Name (if not instituti				Location of Death		4c. County of Deat	
	Washington County 5. Social Security Number		(In yrs. last birthday)	Hagerstowi		8 Date of Birth	Washington (MM/DD/YYYY) 9. Bi	rtholace (State or
Funeral Director	502-14-0359		85 Yrs	Months Day		_	15	
y any	Usual Residence of Decedent 10a. State 10b. County	erick	Oc. City, Town or Locat Frederick					10d. Inside City Limits
ryland a-f show to once.	Maryland Fred 10e. Street and Number	erick		10f. Zip Code		100	g. Citizen of What Cou	1 Yes 2 No Intry?
h the Maryland 3a or 28a-f sh totified at once		gwater Court,		21703			U.S.A.	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 1 3 X Widowed 4 D	12. Was Decedent E Armed Forces? 1 Yes 2 vorced If Yes, Give Year			spanic Origin? (S _I n, M exican, Puerto o s <i>pecify:</i>		White, etc.	ite
"natura "natura Exami	15. Decedent's Education (Sp Elementary/Secondary (0-12		during m	ost of working life	tion (Give kind of version). DO NOT use reti		16b. Kind of Business	
5-0036 ed within 72 hour. tygiene. other than "natu the Medical Exan Completed	12		Vio	ce Presid		(F-1) A f-1	Banking	
215-(be filed v ntal Hyg rked oth ent, the		e, Last)			18 Mother's Name Katl	nerine Ur		
MD 21 2 should th and Me 27 is max To	19a. Informant's Name/Relation Kathryn L. Cha			Address (Stree Elkridge	et and Number or I e Lane, I	Rural Route Numb Trederic	er, City or Town, Stat k, MD 2170	e, Zip Code) 1
More, Pages 1 and ent of Healing: If item	20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other 8	n 3 Removal from State	20b. Place of Dispos crematory or off Smithsbur	har alasa)			20c. Location - City o 10 Smiths	
Baltii permit. Departm Importa	21. \$ nature Funeral Serv	e ice/see	M00255 10	Reeney 6 East	and Basfe Church S	ord PA Fi	uneral Hom erick, MD	21701
Physician /Medical	23a. Part I. Enter the disease, of failure. List only one caus	on each line.		he mode of dying	, such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a consec						
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	quence of):					
0, sician and burial - transit edical Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consected)	quence of):					
60, e be execu ysician am burial - trr	UNPENDED	AMENDED						
		the 23c. If yes, outcome 1 Live birth 4 Pregnant at ti	2 Fe	tal death 3	Ectopic pregna	ancy	23d. Date of deliver Month	Day Year
he death y the att	1 Yes 2 No 9 U	tions contributing to death	but not resulting in the u		given in Part I	23e. Did tob	acco use contribute to	the cause of death?
res that signed by be detailed by by						1 Yes	2 ✔ No 3 Pro	bably 4 Unknown
Division of Vital Records, P.O. Box 6876 rat or Attending Physician: The law requires that the death certificaters after death. *I Director: After this certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the ertification: To Be Completed by Physician/M						24a. Was ar autops perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of
tal Rector, pa				26.Plac	e of Death (Check	only one)		
of Vital Recoing Physician: The law After this certificate has Sureral director, page 2 son: To Be Comp	1 Yes 2 No	Hospital: 1 Inpatien 28a. Date of Injury			Other Nursin		tesidence 6 Othe	er:
ion of 'leading Pheath. tor: After t the funeral	1 Natural 5 Per 2 Accident	28a. Date of Injury (Month, Day Yes Dec 7, 2010	1500 hrs	1	Yes 2 ✔ No	Subject fell	_	
Division o spital or Attending tours after death. neral Director: Affilled in by the fune Certification:	3 Suicide 6 Co	ald not be	iry - At home, farm, stre ii-Family Apt.	et, factory, office	building, etc.	or Town, Sta		ural Route Number, City , MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification		Physician: To the best of my aminer:On the basis of exam						
To with to the con	29b. Signature and title of certif	and manner stated		29c. Licen		Ī	29d. Date signed (Me	
	30. Name and address of perso	n who completed cause of de	ath (Item 23a)	O.C.	.M.E.		December 10, 2	.010
	Russell Alexander M	Assistant Medica	I Examiner 111		, Baltimore, M	D 21201		
State Registrar	1111.	2 0 2010 ^{32. Registrar}	s Signature	backer				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 10d per DVR G910 12/20/10 dk State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day₁ Physician/ Month ASSAL Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY omp 8. Date of Birth 9. Birthplace (State or Foreign Country) OI+10 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** M 2 □ F (Month, Day, Year Months Hours Min **Director** 28a-f show 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits notified at Director WASHINGTON 1 Yes 2 No 10f. Zip Code 10e. Street and Number ö 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 24th STNW FEOUS USA APT 505 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces? 1

Yes 2 □ No ARMY

If Yes, Give

Year or Dates. 1954 -1458 Black, White, etc. 1 Never Married 2 Married "natural", or ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 - Widowed 4 Divorced BLACK and Mental Hygiene.
Is marked other than "natul 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PHOTOG-RAPH PHOTOGRAPHER 13 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 FRANK DWENS MINNIE permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic onee. traumatic MAE MILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30344 RASHIDA OLIVER MALIC HTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place X 12-10-10 STAFFORD VA 21. Signature of Funeral Service Licens serevity funeral svi 22. Name and Address of Facility FILLIT EE RO CHANTILL Mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ 2 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Osque, tidily list soliditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit vemic and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an the funeral director, page 2 this certificate has autopsy performed 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: ၉ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 5 Pending injury 1. Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director, 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 12 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 2 0 2010 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 7:30 A M December Donald R. Butler, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6813 Plantation Road Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Year) 19<u>31</u> Days 1 XM 2 - F Months Min. June 15, 79 Mary land 218-24-9131 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States 6813 Plantation Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Divorced 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "in Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner & Operator Tire Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harvey Butler Catherine Zepp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 6813 Plantation Rd., Frederick, MD 21701 Betty Butler / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/4/2010 Olivet Cemetery Frederick, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home ous 1621 Opossumtown Pike, Frederick, MD 21702 23a. Fig. Enter the disease or complications that Alfed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Ist only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy Month Year Pregnant at time of death Unknown signed by the a 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) completed filled in by the funeral director 2 No Other: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month

State Registrar 30. Name and address of person

EMAMY E 31. Date filed (Month, Day, 5

nder

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2220 M Oro 2010 to vember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 101pital Memorial Talbot taston If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😿 F (Month Day Year **Director** lano Usual Residence of Decedent or items 23a or 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at hours after death with the Maryland Director 1 De Yes 2 No Talbat 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: "natural", Completed 3 Widowed 4 Divorced ack permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) DUNTE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Harrison James Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter ookiwa V <u>MD.</u> ton Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOME, P. uneral Henry Shi water St MD. 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Sepsic Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner POXIC En cer halo Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit tailure the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 ☐ Yes 2 № 9 ☐ Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? onnar 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 5 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann⇒ of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) า 24 hours a e Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Mohan D0069 561 MD Dec 06 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohan, M.D. 219 South Washington Street, Easton, MD 21601 31. Date filed (Month, Day, Year)

DEC 0 8 2010 Registrar's Signata State Registrar

Lack

	For State of M	laryland / Depa	artment of H	lealth and	Mental Hy	giene	-	
	State Registrar	Cei	rtificate of E	Death		Reg. No	010	10115
n/	1. Decedent's Name (First, Middle, Last)	_1			Date of De Month	ath Day	Year	3. Time of Death
al	Bobby Lee Bra	dy			(2	4	2010	2240 M
er	4a. Facility Name (if not institution, give street and number)	,	4b. City, Town, or	Location of Dea			ounty of Death alvert	1
	Calvert Memorial Hospital 5. Social Security Number 16. Sex 17. Ac	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 H				pplace (State or Foreign
	218-36-3255 1X M 2 □ F	72 Yrs.	Months Days	Hours Mi			Mary	Tand
	Usual Residence of Decedent							
ctor	10a. State 10b. County	10c. City, Town or Lo	ocation					10d. Inside City Limits
Jire	MD Calvert 10e. Street and Number	Owings	106 7in Code			10 0111		1 Tes 2 No
rall		A	10f. Zip Code	736			on of What Cou $S.A.$	intry?
une	9206 Southern Maryland Blv				Specify Yes or No-		1. Race - Ameri	ican Indian
oy F	Armed Forces? 1 ☐ Never Married 2 ☒ Married 1 ☑ Yes 2 ☐ 1 ☑ Yes, Give] No	Was Decedent of Hi If Yes, specify Cuba		erto Rican, etc.)		Black, White,	
ed	3 ☐ Widowed 4 ☐ Divorced If Yes , Give Year or Dates.	1959-63	1 ☐ Yes 2 🛣 No	Specify:		Sp	pecify: W	hite
Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o		orking	16b. Kind	d of Business I	ndustry
Som	Elementary/Seconday (0-12) College (1-4 or	5+)	NOT use retired)				constru	iction
Be (17. Father's Name (First, Middle, Last)	l ca	ii penter	18 Mother's N	lame (First, Middle,			
읻	Thomas Joseph Brad	y		Addie	Rebec		Griers	son
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or F	Rural Route Numbe	r, City or To	own, State, Zip	Code)
	Muriel S. Brady, wife	9206	Southern	Mary1ar	nd Blvd.,	Owin	gs, MD	20736
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Renfoval from State	20b. Place of Dispo cemetery, cren	osition (Name of matory or other plac	e)	Date	20c. Loca	ation - City or T	Town, State
	4 🖰 Donation 5 🗆 Other (Specify)	Smithvill			09/2010		irk, MD	
	21. Signature of Funeral Service Licensee	/	2. Name and Addres $3325~{ m Mt.}~{ m I}$	Г	Rausch Fu	neral	Home,	P.A. 0736
	23a. Part 1. Enter the disease, or complications that cause	d the death. Do not ente					110 20	Approximate
	shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	ne.	6 6	0.0				Interval Between Onset and Death
	resulting in death) a. Due to (or as	a consequence of):	3.71 61	arev.				4.45
<u>.</u>	Sequentially list conditions, bak\	o with	RVR					goods
Examiner	if any, leading to immediate Due to (or as cause. Enter Underlying Cause (Disease or liniury	a consequence of):						
Exa	that initiated events C.	a consequence of):						
ica	d							
Med	IF FEMALE:							
an/l	23h Was decedent pregnant 23c. If yes, outcome		Ectopic pregnanc	у		23	d. Date of deli	
ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant : 9 ☐ Unknown 9 ☐ Unknown	at time of death 5	Other (specify)				Month	Day Year
Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
d b	CAP, HTW, COPD	, Hypon	atrens	ià,	1 🗆	Yes 2 🗆	No 3 ☐ Pro	obably 4 📈 Unknown
lete	Charies and is	P	` C	,	24a. Was	an	24b. Were auto	opsy findings available
omp		- Coppies	7		autor perfo	rmed?	prior to codeath?	ompletion of cause of
še C	25. Was case referred to medical		26. Pla	ace of Death (Ch		2 🗶 No	I L Yes	Z LI NO
고 E	examiner? 1 ☐ Yes 2 🗚 No Hospital: 1 🛣 Inpat	tient 2 ER/Outpatier	nt 3 🗆 DOA Othe	er: 4 Nursing	Home 5 Resid	dence 6	Other (Specif	(v)
ate:	27. Manner of Death 28a. Date of inju 1 Natural 5 □ Pending (Month, Da	ury 28b. Time of injury	work	?	28d. Describe h	now injury o	occurred	
tilic	2 Accident Investigation			Yes 2 No				
Cer		jury - At home, farm, str ic. <i>(Specify)</i>	eet, factory, office		28f. Location (S City or Tow		Vumber or Rura	al Route Number,
Medical Certificate: To Be Completed by Physician/Medical	29a. Certifier 1 Certifying Physician: To the best o							
Med	(Check 2 Medical Examiner: On the basis of conly one) 3 Certifying Nurse Practioner: To the							
	29b. Signature and title of certifier	// .	29c. License		C 3		signed (Month,	
		17		00617	0 ->	12	13/2	010
	30. Name and address of person who completed cause of	death (Item 23a) (Tybe, F > 100 Host	_{Print)} pital Roa	d, Princ	ce Freder	ick,	MD 206	78
е		20: 1						
r	DEC = 6 2010 \(\alpha \)	Enews B.	parker					

DHMH 17 Rev 7/2009

Stat Registra

2 my 5+1

			Please	e Type or Pri					•		•	
	•	For State Registrar			arylan		artment of rtificate of	Health and Death	Mental Hy	/gien Reg. N	2010	0 6
Physicia Medic		1. Decedent's Name Arnold	e (First, Middle, La	ast)	В	ortman			2. Date of D Novemb		30, 20 [°] 10	3. Time of Death 2:48A M
Examin	er	, ,	. 0	re street and number) ntist Hosp	it al		4b. City, Town, Rockvil	, or Location of Dea $11e$	ath		c. County of Dear	
Funeral Director		5. Social Security Nu 050–18–9	730	. 1771	e (In yrs. k 3 7	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Day			irth 7 192	g. Bir Mass	thplace (State or Foreign untry) Sachusetts
/aryland 8a-f show tified at	Director	Usual Residence of 10a. State MD	10b. County Montgom	ery		y, Town or Lo						10d. Inside City Limits 1 Yes 2 □ No
s 23a or 2 ust be no	Funeral Di	10e. Street and Num 10500 Ro		Pike, #170	3		10f. Zip Code 2085	52 - 3359			Citizen of What Co	,
irs after death ural", or item I Examiner n	by	11. Marital Status 1 ☐ Never Marri 3 ☒ Widowed	ed 2 Married	12. Was Decedent I Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.		-II	Was Decedent of If Yes, specify Cu	f Hispanic Origin? (uban, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)) -	14. Race - Ame Black, Whit Specify: Wh	
thin 72 hou ene. than "natu he Medical	Completed	(Spec	15. Decedent's cify only highest g onday (0-12)		5+)	(Give	dent's Usual Occ kind of work don O NOT use retire	e during most of w	orking		Kind of Business	
d be filed wi Mental Hygid arked other aric event, t	To Be (17. Father's Name (F			18. Mother's Name (First, Middle, Maiden Surname) Nettie Wallace							
nd 2 shoul ealth and I n 27 is ma er trauma	2	19a. Informant's Na Nadine L				19b. Maifi 14431	ng Address (Stree Sugarla	et and Number or F and En Po	Rural Route Numb olesvill	er, City .e , 1	or Town, State, Zi _l	o Code)
permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Up the Maryland Emporath: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- A		Cremation 3 5 5 Other (Spec		0	emetery, crei ng Dav	osition (Name of matory or other p id Mem (2. Name and Add hapels,	Gdns 12/	Date 02/2010 nzansky- 70 Rocky	Fa	Location - City or 11s Chur Iberg Men 2 Pike	ch, Virginia
୍ଥିଆ ଜ	ical Examiner	23a. Rant 1 Ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart afficie. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ininjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death
within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis (pmpleted filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	Fetal death 3 Ectopic pregnancy					23d. Date of de Month	livery Day Year
law requires triar to as been signed be a should be deta	npleted by P	Part II. Other signifi	cant conditions	contributing to death b	ut not res	ulting in the u	inderlying cause	given in Part I.	1 24a. Was	Yes :	2 No 3 P	othe cause of death? robably 4 Unknown topsy findings available completion of cause of
ertificate h	Be	25. Was case referre examiner?		Lipositol.			1 "	Place of Death (Ch	1 🗆 Yes	ormed?	death?	5 2 □ No
ath. r: After this o e funeral dire	은	1 Yes 2 2 27. Manner of Death 1 Natural 2 Accident		28a. Date of inju (Month, Day	ry	ER/Outpatier 28b. Time of injury	28c. Inj		Home 5 Res 28d. Describe		6 Other (Spec iry occurred	ify)
urs after deg ral Director lled in by th	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	building, etc	. (Specify,)			City or To	wn, Stat	e)	ral Route Number,
the Fune	Medical	(Check 2 only one) 3	 Medical Exan □ Certifying Nu 	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination	n and/or inves	tigation, in my opi death occurred at	inion, death occurred the time, date and p	d at the time, date	and place he cause	e, and due to the es	cause(s) and manner stated. stated.
25		29b. Signature and t	y dy	, M. D ,	ooth (V	920) / 1	D00	65505			ate signed (Month	30 2010
		30. Name and addre	G CHEN	completed cause of de D	9901	MEDIC	,	TER DRIVE	ROCK	IILL	E MARY	ILAND 20850
State Registra		· ·	C 06 20		a s signat	10						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Larry Robert Brooks 2010 10:09 A M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Mt. Airy 13985 Mater Way If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🔀 M 2 🗆 F Sept 16, Year 949 220-48-0513 61 Washington, D.C Director Usual Residence of Decedent ms 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d, Inside City Limits Director Maryland Frederick Mt. Airy 1XXYes 2 No 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral 13985 Mater Way 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten I Examiner r 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1969 1 ☐ Yes 2X No Specify: white "natural", 3 Wildowed 4 Divorced Specify: 1973 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) U S Post Office Letter carrier traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Health and Mental Health and injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Muriel Bryant Clay E. Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Brooks - wife 13985 Mater Way, Mt. Airy, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Crownsville V.A. Cemetery
Dec. 7, 2010 1 XBurial 2 Cremation 3 Removal from State Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 22. Name and Address of Facility uneral Service Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Ischemic Heart disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 XNo Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗹 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ieral Director: A filled in by the fu Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D 400 41311 2010 usi a- Lleuchah 30th

Registrar
DHMH 17 Rev 7/2009

State

- 20528 Boland Farm Road, Germantown, Maryland

20876

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yuri A. Deychak,
31. Date filed (Month, Day, Year)

M.D.

32. Regist ar's Signature

Fune Direct

	-	State Registrar			Cer	tificate of L	Death		Reg	No. No.	10	1011
ian/	1	. Decedent's Name (First, Middle, L.	,					Mon	of Death	3° 20	-Year	3. Time of Death
ical	11	John Joy Broo				41. Cit. T	1		mber			5:18 A.
iner	40	Northhampton				4b. City, Town, or Frede		or Death		4c. County		
ı		. Social Security Number 6.	Sex 7. Age	(In yrs. last b	irthday)	If Under 1 Year	If Under			and I	9. Birt	thplace (State or Fore
r	_	223-44-6/2/	1 X M 2 □ F 8	33	Yrs.	Months Days	Hours	Min. Nov.	h, 9 ay, Ye	1927	Virg	ginia
١	_	Usual Residence of Decedent Oa. State 10b. County		10c. City, Tox	wn or Loc	ation						10d. Inside City Lim
Director		Maryland Freder	ick	Fred	leric	k						1 ☐ Yes 2 ☐
	1	0e. Street and Number	-		-	10f. Zip Code			100	g. Citizen of W	Vhat Co	untry?
Funeral	L	5602 Honeysuckle	Court			21	703			USA		
	1.	1. Marital Status	12. Was Decedent E Armed Forces?		13. W	/as Decedent of Hi Yes, specify Cuba	spanic Ori n, Mexicar	gin? (Specify Yes o , Puerto Rican, etc	r No- :.)		e - Amer k, White	rican Indian, e, etc.
d by		1 ☐ Never Married 2 🔼 Married 3 ☐ Widowed 4 ☐ Divorced	1 A Yes 2 1 If Yes, Give Year or Dates.	No	1	☐ Yes 2 🔀 No	Specify:			Specify:	V	white
Completed	F	15. Decedent's	Education	16	Sa. Deced	cedent's Usual Occupation re kind of work done during most of working			16	ib. Kind of Bu	siness I	Industry
I W	1	(Specify only highest of Elementary/Seconday (0-12)	College (1-4 or 5-		Ìife. DC	NOT use retired)	•	t of working				
Be C	-	12 7. Father's Name (First, Middle, Last			Staff	special				Vitro		
일	l'	Jonathan Palmer	,					er's Name <i>(First, M</i> cances Jo		den Surname,)	
	1	19a. Informant's Name/Relationship		19	9b. Mailin	g Address (Street a				tv or Town. St	tate. Zio	Code)
		Ann S. Brooks -	wife			Honeysuc						
	20	0a. Method of Disposition	Damas al fram Chata			sition (Name of atory or other plac	e)	Date	20	c. Location -	City or	Town, State
		1 ☐ Burial 2 🔀 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Stauff	fer C	rematory		12-7-201)	Frede	rick	k, Marylar
	2	1. Signature of Funeral Service Lice	nsee .	of of	- 1	Name and Addres		, pranii		uneral		
_	L		nulle G	line		21 Oposs					Maı	ryland 21
	1	23a. Part 1. Enter the disease, or co- shock, or heart failure. List only	one cause on each line.			r the mode of dying	g, such as	cardiac or respirat	ory arrest,			Approximate Interval Between Onset and Death
_		mmediate Cause (Final disease or condition resulting in death}	a. Dene								_	40 MTHS
			Due to (or as a								1	MO NTHS
	r S	disease or condition resulting in death) Sequentially list conditions, f any, leading to immediate	a	consequence	e of):							~ 0 NTHS
	r Sitt	disease or condition resulting in death) Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	a. Due to (or as a	consequence	e of):							M 8 M T H S
Examiner	iii co	disease or condition esulting in death) Sequentially list conditions, f any, leading to immediate cause. Enter Underlying	a. Due to (or as a	consequence	e of): e of):							M 6 N 7 H S
Examiner	iii co	disease or condition resulting in death) Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	b. Due to (or as a	consequence	e of): e of):							* 6 N T H S
Examiner	r Sid	disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c. Due to (or as a d.	consequence	e of): e of):				-			0 7743
Examiner	r Sid	disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months?	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome c 1 Live Birth 2	consequence consequence consequence pregnancy consequence	e of): e of): e of):	Ectopic pregnanc	у			23d. Dats		0 7743
sician/Medical Examiner	r Sid	disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome c.	consequence consequence consequence pregnancy consequence	e of): e of): e of):	Ectopic pregnanc Other (specify)	у					ivery
Physician/Medical Examiner	r Silico Ct tr	disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or	consequence consequence consequence of pregnancy Consequence consequence	e of): e of): e of): ath 3	Other (specify)		l. 23e.	Did tobac	Mon	nth	ivery
by Physician/Medical Examiner	r Silico Ct tr	disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or	consequence consequence consequence of pregnancy Consequence consequence	e of): e of): e of): ath 3	Other (specify)				Mon	bute to	ivery Day Year
by Physician/Medical Examiner	r Silico Ct tr	disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or	consequence consequence consequence of pregnancy Consequence consequence	e of): e of): e of): ath 3	Other (specify)			1 Yes	Monocco use contri	ibute to	ivery Day Year the cause of death? robably 4 1 Unknotopsy findings availate
by Physician/Medical Examiner	r Silico Ct tr	disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or	consequence consequence consequence of pregnancy Consequence consequence	e of): e of): e of): ath 3	Other (specify)		24a.	1 🗌 Yes	Monocco use contri	bute to 3 Pr Vere autrior to cleath?	ivery Day Year the cause of death?
Physician/Medical Examiner	IF 23	disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events esulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or	consequence consequence consequence of pregnancy Consequence consequence	e of): e of): e of): ath 3	Other (specify) nderlying cause giv	en in Part	24a.	1 Yes Was an autopsy	Monocco use contri	bute to 3 Pr Vere autrior to cleath?	ivery Day Year the cause of death? robably 4 Unknown copy, findings availate completion of cause of
To Be Completed by Physician/Medical Examiner	IF 23	disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or	consequence consequence consequence of pregnancy consequence of pregnancy consequence time of death at not resulting	e of): e of): e of): g in the ur	Other (specify)	ace of Dear	24a. 1 □ th (Check only one irsing Home 5 🗡	1 Yes Was an autopsy performer Yes 2 Residence	Mor 2 No 24b. W p d2 No 1	ibute to 3 Pr Vere aut rior to ceath? Yes r (Speci	ivery Day Year the cause of death? robably 4 Unknot topsy findings availat completion of cause of
To Be Completed by Physician/Medical Examiner	IF 23	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Fart II. Other significant conditions 5. Was case referred to medical examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or	consequence consequence consequence consequence consequence f pregnancy 2 Fetal death time of death at not resulting	e of): e of): e of): g in the ur	Other (specify) 26. Pla 3 DOA Other 28c. Injury	een in Part	24a. 1 Check only one ursing Home 5 X	1 Yes Was an autopsy performer Yes 2 Residence	Mor 2 No 24b. W p d2 d2 No 1	ibute to 3 Pr Vere aut rior to ceath? Yes r (Speci	ivery Day Year the cause of death? robably 4 Unknot topsy findings availat completion of cause of
To Be Completed by Physician/Medical Examiner	IF 23	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events esulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as	consequence consequence consequence consequence properties of pregnancy consequence of pregnancy consequence conse	e of): e of): e of): g in the ur Outpatient Time of injury	Other (specify) 26. Pla 3 □ DOA Other 28c. Injury work M 1 □	ace of Deal	24a. 1 L th (Check only one ursing Home 5 X 28d. Desc	1 ☐ Yes Was an autopsy performer Yes 2 Residence ribe how in the second seco	Mon 2 No 24b. W 27 No 1 24b. W D R R R R R R R R R R R R	ibute to 3 Pr Vere aut rior to ceath? Yes r (Speci	ivery Day Year the cause of death? robably 4 Unknot topsy findings availat completion of cause of
Certificate: To Be Completed by Physician/Medical Examiner	IF 23	disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions art II. Other significant conditions 7. Manner of Death 1 Natural 5 Pending Investigati	Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as	consequence consequence consequence consequence properties of pregnancy consequence of pregnancy consequence conse	e of): e of): e of): g in the ur Outpatient Time of injury	Other (specify) 26. Pla 3 □ DOA Other 28c. Injury work M 1 □	een in Part	24a. 1 Lith (Check only one ursing Home 5 X 28d. Desc	1 ☐ Yes Was an autopsy performer Yes 2 Residence ribe how in the second seco	Mon 2 No 24b. W 27 No 1 No 1 No 1 No 1 No No No	ibute to 3 Pr Vere aut rior to ceath? Yes r (Speci	ivery Day Year the cause of death? robably 4 Unknown dopsy findings availate completion of cause of the caus
Certificate: To Be Completed by Physician/Medical Examiner	P 28	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events esulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	Due to (or as a b. Due to (or as a c. Due to (or as a c. Due to (or as a d. Due to (or as	consequence conseq	e of): e of): e of): ath 3 □ n 5 □ Gutpatient Time of injury farm, streen, death or	other (specify) 26. Pla 3 DOA 28c. Injury work 1 et, factory, office	ace of Deat	24a. 1 L th (Check only one ursing Home 5 X 28d. Desc No 28f. Loca City o	1 ☐ Yes Was an autopsy performer Yes 2 Residence ribe how in the form of th	Mon 2 No 24b. W p d No 1 24b. W p d n to n to n to n to n to n to n to n	ibute to 3 Pr Vere autrior to cleath? Presid r or Run r as sta	ivery Day Year the cause of death? robably 4 Unknown topsy findings availate completion of cause of the completion of cause of the completion of the comple
To Be Completed by Physician/Medical	IF 23	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions 1 Yes 2 No Variable Va	Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as	consequence conseq	e of): e of): e of): ath 3	Other (specify) 26. Pla 26. Pla 3 DOA Other 28c. Injury work M 1 et, factory, office coursed at the time, gation, in my opinio eath occurred at the	ace of Deat ace of Deat ace of Deat act at ? Yes 2 date and n, death oc time, date	th (Check only one sursing Home 5 X 28d. Desc No 28f. Loca City (collace, and due to 1 courred at the time,	Was an autopsy performer Yes 2 Residence ribe how in the cause (state and performer). Town, S	Mon 2 No 24b. W 24b. W 27 Ano 1 24b. W 24b. W 25 25 26 Ano 1 27 28 29 20 20 20 20 20 20 20 20 20	ibute to 3 Pr Were aut rior to ceath? Yes r (Speci d	ivery Day Year the cause of death? robably 4 Unknot topsy findings availat completion of cause of 2 No ify) ral Route Number, ted. cause(s) and manner s
Certificate: To Be Completed by Physician/Medical Examiner	IF 23	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions art II. Other significant conditions 7. Manner of Death 1 Natural 5 Pending Investigation of the condition of the	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or	consequence conseq	e of): e of): e of): ath 3	Other (specify) 26. Pla 26. Pla 3 DOA Other 28c. Injury work M 1 et, factory, office	ace of Deather: 4 Number 2 date and 1 n, death och time, date anumber	th (Check only one trising Home 5 X 28d. Desc No 28f. Loca City (colace, and due to 1 courred at the time, and place, and due	1 ☐ Yes Was an autopsy performer Yes 2 Residence ribe how in the cause (cause Mon 2 No 24b. W 24b. W 27 Ano 1 24b. W 24b. W 25 25 26 Ano 1 27 28 29 20 20 20 20 20 20 20 20 20	hith the to a simple series of the content of the c	ivery Day Year the cause of death? robably topsy findings availat completion of cause of the c	

10 tIVA

State Registrar

31. Date filed (Month, Day, Year)

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PLAYER N & LA NUM, 196 TO JUVE, FLEDRUCK,

32. Registar's Signature

A Southold 32. Registrar's Signature

70-21702.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** THEODORE ALFRED BIVINS 12th 11-2010 3:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES LA PLATA 143 KALMIA COURT 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign WASHY), D.C. 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** Months Days Hours Min Monty, Day, gegry **X**□ M 2 □ F 218-84-6786 36 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Experiment must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits LA PLATA Director MD. CHARLES Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 143 KALMIA COURT U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XNever Married 2 ☐ Married altimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify: ۇ ك 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION WORKER EARNSHAW BROTHERS CO 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EVA ELIZABETH BIVINS THEODORE ALFRED BRISCOE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 KALMIA CT. LA PLATA, MD. 20646 TAKEMA V.BUTLER-SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State HOLY 1 Burial 2 □ Cremation 3 □ Removal from State y, crematory`or GHOST permit. Page Department of Important: If any Injury or once. CEMETERY 12-16-10 ISSUE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00479 AYMOND FUNÉRAL SERV LA PLATA, MARYLAND 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ce -C disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Unidentity Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) Ö 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>6</u> s peen si should ! 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No certificate Division of Vital 2 □No 1 ☐ Yes 1 ☐ Yes Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural death. eral Director: A 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by determined 4 ☐ Homicide the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death PLATA CHARLES If Under 1 Year Age (In vrs. last birthday If Under 24 Hrs 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days Hours Min. 1 M 2 E 90 MARth. 44, 49 20 N Country) Director Usual Re dence of Deceden ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES LA PLATA 1X Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 MAGNOLIA DRIVE 20646 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. and Mental Hygiene. Completed by 1 Never Married 2 Married Yes 2**X** No Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: BLACK 3 X Widowed 4 ☐ Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) WOODWARD & LOTHROP Elementary/Seconday (0-12) 12th College (1-4 or 5+) SALES REPRESENTATIVE STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOSEPH HERRING FANNIE McCULLAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 st tment of Health a CASSANDRA TOLSON-DAUGHTER item 27 8722 PORT TOBACCO RD. LA PLATA, MD. 20646 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State tX☐ Burial 2 ☐ Cremation 3 ☐ Removal from State FT.LINCOLN CEM. 12-16-10 BRENTWOOD, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Fineral Service Licenses RAYMOND FUNERAL S LA PLATA, MARYLAND SERVICE, P.A. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Kenpirotory disease or condition Medical resulting in death) Due to (or as a cons ence f) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury Duki to for as a consequence of and -transit CVA or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 pronths?
1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Pregnant at time of death Day Year signed by the a Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? Yes 2 No death? this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Dea (Check only one) examiner? Hospital 1 🗆 Yes 2/1 No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mary er of Death Certificate: 28b. Time of 28c. Injury at s after death.

I Director: After t 28d. Describe how injury occurred Natural 5 Pending work?
1 \(\subseteq \text{Yes} \) Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral D Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 1131 Dog 70 900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annopolis, MD 21401 DI Mensolit Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23aPtI,25,27 per me, g912,02/04/2011dhb

Reg. No. 1 - For Amend items
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 11 2010 David Luther Buhrman 6:00 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Apr. | 6, 1930 Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 □ F Months Mary land 212-24-7179 80 Yrs Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important if firem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21701 315 West Seventh Street 12. Was Decedent Ever in U.S. Armed Forces? 12 Mayes 2 ☐ No If Yes, Give 1 948 – 1952 Year or Date 1 948 – 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1XXNever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ¬No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Construction Inspector Elementary/Seconday (0-12) College (1-4 or 5+) City Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edna Marie Albaugh Russell Paul Buhrman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Nymber or Rural Figure Nymber, City or Town, State, Zip Cade) 315 West Seventh St., Frederick, MD 21701 Harold E. Buhrman, brother Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mount Olivet Cemetery Dec. 15, 2010 Frederick, MD 4 Donation 5 Other (Specify) Signatu of Foreial Service Lice 22. Weeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Esquer tially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performe No. 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Hame 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) December 1, 2010 Un Kwwn M 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No ictim Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify); 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined at home Medical 29a. Certifier only one)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who 31. Date filed (Month State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Carruthers ์ดี1 2010 3:45 December A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Pasadena Home Care, Inc. Pasadena 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Aug. 19,1951 Birthplace (State or Foreign Country)
 Maryland Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 214-54-7718 59 Yrs. Director Auq. Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show amounts in luny or hother traumatic event, the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Pasadena 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2311 229th Street 21122 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: White 3 Divorced 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Carruthers Margaret White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Anne Slaughter / Sister 2311 229th Street Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 03 1 Durial 2 X Cremation 3 Removal from State Metro Crematory, INC. Baltimore, MD 4 ☐ Donation 15 ☐ Other (Specify) 2020 Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, 23a. Part 1. En lettre circ ase, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause in each line. Approximate Interval Between such as cardiac or respiratory arrest Immediate Cause (Final HOR Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 / Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year 009

State Registrar

Madiso

mi

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

Gorbatu

Day,

071 31. Date filed (Month. 02

1 State Of No.	Ce	ertificate of D		, 0	eg. No.2 0 1 0	40123
1. Decedent's Name (First, Middle, Last)				2. Date of Deati Month		3. Time of Death
Richard Thomas 4a. Facility Name (if not institution, give street and number)		Tu. 65. T.	Learning of Death	Novembe	er 29,2010	0019 A ^M
Shady Grove Adventist Hos		4b. City, Town, or	ville		4c. County of Dea	
5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth	g. Bir	thplace (State or Foreign
263-47-3800 1 M 2 F Usual Residence of Decedent	47 Yrs.	World S Days	Hours Will.	Feb. 28,	1963	vintry) Virginia
10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
Maryland Montgomery		D	amascus			1 🗆 Yes 2 🖪 No
10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	ountry?
6 Crosscut Court			0872		USA	
11. Marital Status 1 □ Never Married 2 ■ Married 12. Was Decedent Armed Forces 1 □ Yes 2 ■	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	panic Origin? (Spe , Mexican, Puerto	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
3 Widowed 4 Divorced If Yes, Give Year or Dates.	NO	1 ☐ Yes 2 ■ No	Specify:		Specify: V	Thite
15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupa kind of work done du	tion	na	16b. Kind of Business	Industry
Elementary/Seconday (0-12) College (1-4 or	1160 1	OO NOT use retired)	_	1	***	
17. Father's Name (First, Middle, Last)		Sr. Proje	18. Mother's Name			ance
Jacques H. Croom, S	r.		10, Mother 3 Name	, ,	andsdale (Proom
19a. Informant's Name/Relationship (Type, Print)		ing Address (Street ar	nd Number or Rura		City or Town, State, Zi	
Kathryn A. Croom/ Wife	6 C ₁	cosscut Co	urt, Dama	ascus, M	D 20872	
20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from Stat	20b. Place of Disp				20c. Location - City or	Town, State
4 Donation 5 Other (Specify)	All Souls	s Cemetery	Dec.			, Maryland
21. Signature of Fineral Service Lice See	CFSP 1	2. Name and Address Molesworth 26401 Ridg	of Facility -William; e Road,]	s, P.A., Damascus	Funeral H , MD 20872	lome
23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir	ed the death. Do not ent	ter the mode of dying	, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
discuss of condition	ratory a	arrest				Onset and Death
resulting in death) Due to or as	a consequence of):	And a series of the contract o	- 4			Hlan 1100
Sequentially list conditions, if any, leading to immediate	a consequence of	Termino	4			4hours
cause. Enter Underlying Cause (Disease or linjury	' h	ral nervou	9 system	lymph	pma	7 months
that initiated events resulting in death) Last C. The Due to (or as	a consequence of):		1	11		
d						
IF FEMALE: 23c. If yes, outcome	of programmy					
in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
9 Unknown 9 Unknown	ar into or double of					
Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
			.	1 □ Ye	s 2 🗆 No 3 🗆 P	robably 4 X Unknown
				24a. Was an autopsy		topsy findings available completion of cause of
				perform 1 \sum Yes 2	ned? death?	s 2 □ No
25. Was case referred to medical examiner? Hospital:		Other	ce of Death (Check	only one)		
1	ient 2 ER/Outpatie	nt 3 🗆 DOA	4 L Nursing Hor	me 5 Resider	nce 6 Other (Spec	ify)
1 Natural 5 ☐ Pending (Month, Da 2 ☐ Accident Investigation		work?	es 2 🗆 No	eda. Describe nov	vinjury occurred	
3 ☐ Suicide 6 ☐ Could not be	ury - At home, farm, str	reet, factory, office			eet and Number or Ru	ral Route Number,
L	c. (Specify)			City or Town,	State)	
29a. Certifier (Check only one) Certifying Physician: To the basis of a Medical Examiner: On the basis of Certifying Nurse Practioner: To the	examination and/or inves	stigation, in my opinion	, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
29b. Signature and title of certifier	0110	29c. License	number	29	d. Date signed (Monti	n, Day, Year)
Clincy Chullo	- IVI	MD 6	2580	//	1/29/201	0 000
30. Name and address of person who completed cause of a Nancy Churosh MD 99	death (Item 23a) (Type, I	al Center L	nive, Re	ckville	MD 20	850
31. Date filed (Month, Day, Year) 32. Registor 7 201	ar's Signature	parked				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ıryland	-	rtment of F tificate of D		Mental Hy	gien Reg. N	711	0	40124
	Physicia		1. Decedent's Name <i>(First, Middle, La:</i> MTCHAEL	GERALD		CASE			2. Date of De Month Decemb		^{2y} , 20:	Year L	3. Time of Death 12:02 A _M
	Medic Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or Freder	Location of Death			c. County o		7
	Funeral		Frederick Memo: 5. Social Security Number 6.5	ex 7. Age	(In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	rth	T	9. Birthp	lace (State or Foreign
	Director 3		185-66-3493 Usual Residence of Decedent	Z W Z L F	37	Yrs.			April April	5,	1973	Penns	ylvania
	a-f sho	ctor	10a. State 10b. County		10c. City,	Town or Loc						10	0d. Inside City Limits 1 ☐ Yes 21√2 No
	the Ma or 28s	Dire	Maryland Frede 10e. Street and Number	rick			Knoxvi116	2		10g. C	itizen of W	hat Count	
	th with ms 23a must b	Funeral Director	1958 Jefferson Pi					758			USA		
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give		If	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2X☐ No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race Black Specify:	, White, e	etc.
2	hours natura dical E	Completed	15. Decedent's E (Specify only highest gr				ent's Usual Occupa		la fine	16b.	Kind of Bus	Whi	
121	ithin 72 ene. • than " he Med	Somp	Elementary/Seconday (0-12)	College (1-4 or 5+	-)	life, DC	ind of work done d NOT use retired)		king			- m - i - m - i	_
Maryland 21215-0036	filed wi al Hygid t other vent, t	Ве	17. Father's Name (First, Middle, Last)	+4		ETE	ctrical E	18. Mother's Nan	ne (First, Middle,		ngine Surname)	SL TII)	5
<u>Ş</u>	uld be d Menta marked natic e	To	Michael Case	Common Profession					rudy Ri				
2	2 # 2 #		19a. Informant's Name/Relationship (7) Marsha Case /		Ī		g Address (Street a Jeffersor						ode)
Jore	ge 1 and nt of Heal t: If item?		20a. Method of Disposition 1 Burial 2 Cremation 3		cer	netery, crem	ition (Name of atory or other place		Date	l	_ocation - 0	•	·
Baltımore,	permit. Page 1 a Department of I Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Special Service Licenter)	**	Park		nts Cemet		Stauffe			_	Maryland me
n	9 9 E E 9		23gl. Part 1. Enter the disease, or com	Stauffe	the death		100 North				wick,	MD 2	
~ [Ph sician/		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.						rest,			Approximate Interval Between Onset and Death
لجمد	Medical Examiner		resulting in death)	a. Due to (or as a	conseque	nce of):	ncer	· :	0 1/10-				
	1	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a			y e	M 000	ism				
	scuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	conseque	nce off.							
3	cate be executed physician and sthe burial-transit	edical E	resulting in death, East	I d	oonsoquei	nec dij.							
	ertificate ding ph	/Med	IF FEMALE:	23c. If yes, outcome o	f pregnanc	CV.				0			
POX	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death: within 24 hours after death: to the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Fetal o	death 3 🗌	Ectopic pregnancy Other (specify)	Į.			23d. Date Mont		ry Day Year
J.	that th	by Ph	Part II. Other significant conditions of	ontributing to death bu	t not result	ting in the ur	derlying cause giv	en in Part I.	23e. Did t	obacco	use contrib	oute to the	e cause of death?
ras,	equires	eted											ably 4 Unknown
Vital Records,	The law i ate has b page 2 s	Completed							24a. Was auto perfo 1 \subsection Yes	psy ormed?	pr de		sy findings available npletion of cause of 2 No
Ita	sician: certific	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	م مالات	D/Outpation	Othe	r: (Chec	, ,		. Tou	(0	
101	ing Phy fter this uneral c		27. Manner of Death 1. ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	/ 2	8b. Time of injury	28c. Injury work	?	28d. Describe h				
DIVISION	Attend or death ector: A by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injur	y - At hom	e, farm, stre		Yes 2 □ No	28f. Location (\$			or Rural I	Route Number,
2	pital or ours afte eral Dir			building, etc.					City or Tov				
	ne Hosi in 24 ho ne Fune pleted f	Medical	(Check 2 Medical Exam	sician: To the best of m iner: On the basis of exa se Practioner: To the b	amination a	and/or investi	gation, in my opinio	n, death occurred a	t the time, date a	and place	e, and due t	o the cau	se(s) and manner stated.
	Vith Vith Com	-	29b. Signature and title of certifier	01-0	hac	A	29c. License			29d. Da	ate signed (Month, D	ay, Year)
	•		30. Name and address of person who	Completed cause of dea	ath (Item 2	3a) (Type, Pr		65443	<u> </u>	10	702	-//	
	12		Elena Jarik			744	5+ F	rederic	k mi	0	217	01	
	Stat Registra		31. Date filed (Month, Day, Year) DEC 7	2010 32. Registrar	s Signatur	A. 1	parke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Irene Beatrice COOK 4, 4:30a.M December 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Homewood Nursing Home Williamsport nder 1 Year | If Under 24 Hrs. Washington

9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 94 1 □ M 2 🕅 F 217-42-7779 Director May 3, Maryland 1916 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examination and the codified at 1 ☐ Yes 2X No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1658 Virginia Avenue Funeral 21795 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify \$ Specify: white 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) grade completed Elementary/Secondary (0-12) 12filed within Hygiene. College (1-4or 5+) her own home O homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental h Be Daisy ၉ John Lerov Henesy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum Gudrun Cook daughter-in-law 959 Noland Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Surial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem. Park Dec. 8,2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Kalist 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 ☐ Unknown detach à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 ☐ Yes 2 No 1 🗆 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1☐ Yes 2√2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation hours after death. uneral Director; Aft sly filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of ception 29c. License number who completed cause of death (Item 23a) (Type, Print) enuly

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #5 per FH G920 10/12/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Secember Day 6 2010 0010 AM Benjamin Sylvester Cantler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death **Examiner** Kockville Grove Monta HOSPIT omery If Under 1 Year If Under 24 Hrs 5. Social Security Numbe 6**381** 218–34–6318 6. Sex 1 🖾 M 2 🗆 F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State of Foreign **Funeral** Months Hours Nov. 13, 1 Country) Marvland Director โ938 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 🗌 Yes 2🏝 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24744 Cutsail Drive 20872 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Montgomery County and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 Public Schools Maintenance Worker Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 2 Delmer C. Cantler Anna Elizabeth Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose E. Cantler/ Wife 24744 Cutsail Drive, Damascus, Maryland 20872 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 12/11/10 Rockville, Maryland. 21. Signature of 5 eral Service Licen 22. Name and Address of Facility Stauffer Funeral Homes 1621 Opossumtown Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Obstructive ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Heart Failure Congestive 1 Yes 2 1 No 3 Probably 4 Unknown peen Acute Renal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 2 s autopsy s certificate ha lirector, page 2 Bleed 2 UNC 1 ☐ Yes 2 ☐ No ı ∏ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🖰 No Other: 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation
6 Could not be neral Director: A 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kane, MD se aue D068178 DECEMBER, 06, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD Rane Ctr Dr. MD 9901 Medical 20850 Santosh 31. Date filed (Month, Day, Year, 32. Registar's Signature State DEC

Registrar

0

0

3

21215-0036

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wanda D. Cuzick November 10:10p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12504 Wolf Den Court Monrovia Frederick 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. April 5, 1943 Country) Missouri 67 **Director** 498-46-5058 Usual Residence of Decedent 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12504 Wolf Den Court 21770 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Norman Thomas Dorothy Darlington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Cuzick/ Husband 12504 Wolf Den Court, Monrovia, Maryland 21770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) A11 Souls Cemetery Dec.9,2010 Germantown, Maryland 21. Signature of uneral Service Lice 22. Name and Address of Facility
Stauffer Funeral
1621 Opossumtown Prederick, Maryland 21702 Homes Pike, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death months Immediate Cause (Final Physician/ Acute Lymphoblastic Leukemia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death Other (specify) Year the a g Unknown 9 Unknown signed by tו Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signated by should be 1 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has director, page 2 s autopsy performed? Yes 2 No After this certificate I 2 🗌 No 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury in 24 hours area in the Funeral Director; Af Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29d. Date signed (Month, Day, Year) D0064483 December 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

10

Baltimore, Maryland 21231

Keith W. Pratz MD 401 North Broadway,

32. Regisirar's Signature

31. Date filed (Month, Day, Year)

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 13, 2010 DONALD DAVID COTHIN 11:18a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Millington 371 Cypress St. Kent If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, June 26 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 6. Sex **Funeral** Days Hours Months 11 M 2 □ F 53 Maryland Director 1957 220-62-2348 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examinar must be notified at 1 Yes 2 No Director MD Kent Millington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 and 2 should be filed within 72 hours after death with the ath and Mental Hygiene. 371 Cypress St. 21651 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Completed by Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Road Construction 12 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wayne Jackson Cothin Esther L. Adams ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any injury or other trau Esther Cothin Collins (mother) 371 Cypress St. Millington, MD. 21651 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sudlersville Cemetery 12/18/10 Sudlersville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eurperal Service ²². Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 Approximate Interval Between Onset and Death 23a. Patt The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Immediate Cause in inal **Physician** cardio vascular dise 1 years arteriosole disease or con-line resulting in death) / /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner Due to for as a consequence off if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the burie IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performe certificate Chrenic obstn 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 1 ☐Yes 2 ☐ No s after death 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

Division of Vital Records, within 24 hours a

> State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

W. Bruce Obenshain,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

251 S. Bohemia Ave. Cecilton, MD. 21913

00035779

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 2 Year Physician/ Dortha Lea Cross Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberland WMHS-RMC If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Jan 20 1 □ M 2 □ F 236-62-5434 Director 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WV Paw Paw Morgan 1 Tes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 825 Grandpappy's Lane 25434 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture .aborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Taylor Claude Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie McManus daughtel WV 25434 711 Grandpappy's Lane Paw Paw 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 1 \square Burial 2 \square &remation 3 \square Removal from State 12/9/201D Cresaptown MD 4 Donation 5 Other (Specify) ignature of Funeral Service Licenses 22. Name and Address of Facility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Neumonia disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any leading to in neclate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequend resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe eral Director: After this certificate I filled in by the funeral director, pag 2 No 1 🗌 Yes Yes To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

MD

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D66604

Villow break Rd, Cumberland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DOVE ANCU Physician/ Month 2010 0111 М 2 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 2/2/1954 Birthplace (State or Foreign Country) **Funeral** Days Min 1 M 2 F 213-66-0804 56 **Director** Marvland Usual Residence of Deceden or 28a-f shov notified at 10h Counts 10a State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Davidsonville 1 ☐ Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 3278 Green Ash Rd 21035 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 ☐ Never Married 2 🗓 Married 1 ☐ Yes 2 🗓 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Completed 3 Divorced Specify. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Teacher's Assistant Education ge 1 and 2 should be filed wit to f Health and Mental Hygie If item 27 is marked other or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marvin Smith Dorothy Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elwood J. Dove/ Husband 3278 Green Ash Rd., Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State = 6 Department of Important: If any injury or Ft. Lincoln Cemetery! 12/11/10 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatu 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Yes 2 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2-No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1- Natural injury 5 Pending 2 🗌 No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie or pleted cause of death (Item 23a) (Type, Print) NN APOLU 1)2

State

Registrar

31. Date filed (Mor

144

w

3 2010

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201წ 12:45 P M December Ε. Amy Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Heartfields of Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🏻 F 94 Hours July 19 Country)
Maryland 217-18-7056 Director Ĩ916 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" ---any injury or other traumer. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick 1 🗆 Yes 2 🔀 No Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21701 USA 1820 Latham Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Specify. Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Clarkson Kelly Florence Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2116 Morgan Drive, Flower Mound, TX 75028 James Davis / Son 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 Donation 5 Other (Specify) Mt. Olivet Cemetery 12/8/2010 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform this certificate 25. Was case erred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Ceath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death in 24 hour. the Funeral Direc. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Praetiquer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and titl of certifie 29c. License number address of person who co 31. Date filed (Month, Day, Year 32. Regista r's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010^{ea} James Edward Durst 1304 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13031 St.Paul Road Washington Clear Spring 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Hours oct. 29, Maryland 79 Director 215-26-9721 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Maryland | Washington Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13031 St.Paul Road 21722 USA 12. Was Decedent Ever in U.S. Armed Forces? 1951-12. Yes 2 \(\subseteq \text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXNo Specify: If Yes, Give 1955 3 XXVidowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Leather Processing Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lee Robert Durst Carry Victoria Robison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tommy A. Durst - Son 13035 St. Paul Road Clear Spring, MD 21722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2XXCremation 3 Removal from State 5 Other (Spec Hagerstown Crematory 12-07-2010 Hagerstown, Maryland 21. Signature of F 22. Name and Address of Facility Osborne Funeral Home, P.A. S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Dav Year 9 Unknown 9 II Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 K No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 Nodeclined Hospital Other: ည 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 24 hours after death.
Funeral Director: After this eted filled in by the funeral dir Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 \quad Yes Certificate: 28d. Describe how injury occurred 1 🐼 Natural injury 5 Pending 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F Signate 29d. Date signed (Month, Day, Year) cense numbe ame and address of person who completed cause of death (Item 26a) (Type, Print) 1+ Ethelann Murray, M.D. VA Medical Center 510 Butler Ave. Martinsburg, WV egistrar's Signature State

Registrar

Amend #5, per FD, CCHD, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12/6/10, drw State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 4, Day **Physician** 1:45 P James Clinton Dorsey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1690 Solomons Island Road Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5.25dc&l-Security915mper 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 € M 2 □ F 89 218-24-4574 Director June 8, 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Maryland Calvert Prince Frederick 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 1690 Solomons Island Road 20678 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give 1945–1946 Year or Dates:1945–1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Ite any injury or other traumatic event, the Medical Examines any enter 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) automobile salesman automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Dorsey Sally Fowler မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ethel G. Dorsey— spouse 1690 Solomons Island Road Prince Frederick, Maryland 20678 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec 8 2010 Christ Episcopal Church Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Port Republic Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licensee 4405 Broomes Island Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Mamous /Medical Due o (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) signed by the a d be detached for Ö ☐Yes 2☐No 9 Unknown Δ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 🗌 No neral Director: / 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)
Dec 6, 2010 29b. Signature and title of 29c. License number D17324 impleted cause of death (Item 23a) (Type, Print) erson who dew 6+1 Noble, MD 238 Merimac Ct. Prince Frederick, MD 20678 Raymon A. 32. Registre s Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For _ State	State of M	aryland		artment of F		d Mental H	ygien	е		
			Registrar 1. Decedent's Name (First, Middle, I	ast)		Cer	tificate of D	<i>peatn</i>	2. Date of I	Reg. N	10.20	10	3. Time of Death
	Physicia		Joseph Rich		el				Month Dec.		^{0ay} 201	Year 0	11:15aM
	Medic Examin		4a. Facility Name (if not institution, g				4b. City, Town, or	Location of De			c. County		
	=20011111		Brighton Gard	ens- Tuck	ermar	n Ln	Ro	ckvill	Le	1	Mont	gome	ry
	Funeral			7. Ag	e (In yrs. las		If Under 1 Year Months Days	If Under 24 H Hours Mi		Birth		9. Birthp	lace (State or Foreign
	Director		177-12-2056	IAL W Z L F	86	Yrs.			in. (Month, i	0,1	924		PA
	nd thow	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					1	Od. Inside City Limits
	faryla 3a-f s iified	ect	MD Mont	gomery	,	Rockv	1110						1 ☐ Yes 2 ☐ X No
	or 28	₫	10e. Street and Number	gomery	•	KOCK V	10f. Zip Code		-	10g. 0	Citizen of V	What Coun	try?
	s 23a	Funeral Director	11315 Schuyl	kill Road			208	52		US.	A		
ဖွ	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ice event, the Medical Examiner must be notified at	by Fur	11. Marital Status 1 ☐ Never Married 2x ☐ Marrie			l l	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Pue		0-	Blac	e - America k, White, e	etc.
21215-0036	urs af :ural" al Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	WWII		Yes 2x No				Specify:	Whit	e
5-	72 ho r"nat ledica	Completed	15. Decedent' (Specify only highest			(Give I	lent's Usual Occupa kind of work done o		orking	16b.	Kind of Bu	usiness Ind	ustry
7	ithin iene.	ပ္ပြ	Elementary/Seconday (0-12)	College (1-4 or 5 4	i+)		ONOT use retired) Law Spe	cialia	2 +	l F	ader	a 1 G	ov't
þ	iled w I Hyg othe	Be	17. Father's Name (First, Middle, La	_		IUA	Daw bpe		lame (First, Midd				0 V C
/lar	d be f Aenta arked itic ev	2	Charles F. D	ivel				Alic	ce Elwe	11			
lan	should be filk and Mental I is marked of raumatic eve		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a	and Number or I	Rural Route Num	ber, City o	or Town, S	tate, Zip C	ode)
<u>√</u>	ie 1 and 2 should be t of Health and Men If item 27 is marke or other traumatic		Nell Divel/Wi	fe			5 Schuy	1kill	Rđ., R	$\overline{}$			
Baltimore, Maryland	Page 1 a ment of F ant: If ite ury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐ Removal from State	cen	netery, cren	sition (Name of natory or other plac	e) De	Date 9	20c.	Location -	City or To	wn, State
Ē.	permit. Page Department Important: I any injury o		4 Donation 5 Other (Sp.		Gat		Heaven		2010				ing, MD
<u>a</u>	permit. Page 1 Department of Important; If it any injury or once.		21. Signature of Funeral Service Lic	ensee		于 5	Name and Address 00 Univ	ersity	llins F Blvd.	une:	ral , Si	Home lver	Spring, M
			23a. Part 1. Enter the disease, or conshock, or heart failure. List on	omplications that caused y one cause on each line	the death.	Do not ente	er the mode of dying	g, such as cardi	iac or respiratory	arrest,			Approximate Interval Between
j	hysician/	8 1	Immediate Cause (Final disease or condition resulting in death)	a. End-St Due to (or as	age C	onge	stive H	eart F	ailure			- 1	Onset and Death
	Medical Examiner		resulting in death)			nce of):							
		ē	Sequentially list conditions, if any, leading to immediate	b. Dement		nce of):						-	
	ted Insit	Examiner	Cause, Enter Underlying Cause (Disease or linjury	Hypert	ensio	n						- 1	
	execu an and ial-tra	Ë	that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):							
09	cate be executed physician and the burial-transit	edical		d									
87	rtifica ing ph e as th	Me	IF FEMALE:		. 8	-							
. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as as a completed filled in by the funeral director, page 2 should be detached for use as a completed filled in by the funeral director, page 2 should be detached for use as a completed filled in by the funeral director.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal of	death 3	Ectopic pregnanc Other (specify)	у		-	23d. Dat Mo	te of delive nth	ry Day Year
P.0	that the	by Pl	Part II. Other significant condition	s contributing to death b	ut not result	ting in the u	nderlying cause giv	en in Part I.	23e. Dio	tobacco	use contr	ibute to th	e cause of death?
ds,	quires en sig uld bi								_ 1[Yes 2	2 🔀 No	3 Prob	ably 4 🗆 Unknown
{ecor	he law rec te has bee age 2 sho	Completed							_ pe	topsy rformed?	F	Were autoporior to cordeath?	sy findings available npletion of cause of
a F	an; T	Be C	25. Was case referred to medical examiner?				26. Pla	ace of Death (Ci		s 2 🗀 1	NO	I L les	2 🗀 NO
Ž	hysici nis ce I direc	10 E	1 ☐ Yes 2 🖾 No	Hospital: 1 ☐ Inpati	ent 2 🗆 El	R/Outpatier	it 3 □ DOA Othe	er: 4 🙀 Nursino	g Home 5 ☐ Re	sidence	6 🗌 Othe	er (Specify)	
o	ing Pl		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of inju (Month, Day		8b. Time of injury	work	?	28d. Describe	e how inju	ury occurre	ed	
joi	ttend death stor: A	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	at be	Inc. At hom	o form atra	M 1 L	Yes 2 No	Oof Leasting	£44-			Davida Musekay
N	l or A	Cer	4 Homicide determin	ed building, etc		e, iarm, sire	eet, ractory, office			Street a		er or Hurai	Route Number,
	spita hours neral 1 filled	ical	29a. Certifier 1 Certifying F	Physician: To the best of	my knowled	dge, death c	occured at the time,	date and place	e, and due to the	cause(s) a	and manne	er as stated	d.
	he Hc iin 24 he Fu ipleted	Medical	(Check 2 Medical Ex	aminer: On the basis of e lurse Practioner: To the	xamination a	and/or invest	igation, in my opinio	n, death occurre	ed at the time, date	e and plac	ce, and due	e to the cau	se(s) and manner stated.
	To To To To To To To To To To To To To T		29b. Signature and title of certifier				29c. License	number				(Month, E	
	16-41		the	Mid				D3013	3.2	D.		۷, ۷	010
			30. Name and address of person who Mahashwet		eath (Item 2 MD		Physi	cians	Lane,	Roc	kvil	le,	MD
	Sta Registra		31. Date-filed (Nonth, Day, Year)	37 Registra	ar's Signatur	e							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 10:35 A M Bette Α. Darley Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Columbia Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days Hours Apr 1 1 ay, Year 925 Months Kentucky 85 **Director** <u>405–28–7418</u> Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Howard Columbia 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6642 Seneca Drive 21046 United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates. White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) the Small Business Owner Antique Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James White Allen Flov Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health Lucy M. Carruth/daughter 6642 Seneca Drive Columbia, Maryland 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If its
any injury or of nent of I 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/7/2010 Woodbine, Maryland 21. Sig were of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 thomas Beverly L. Heckrotte, P.A. Clarksville, MD M00957 21029 23a. Part 11 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Urine Infection Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Yes 2 🔀 No ed by the a detached f 9 Unknown g Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas page 2 autopsy performed? certificate 1 Yes 2 No Yes 2 XNo 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this (Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 🔀 Naturai 5 Pending Accident Investigation 24 hours after deat Funeral Director filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physielan: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47447 December 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Suite 103 Columbia, Maryland 21044

Cedar Lane.

6334

32. Registrar's Signature

Astra

M.D.

Andy Lazris,

DEC 0

31. Date filed (Month, Day, Year)

10-09285 James Dills Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ames Dilis	1- For State	Otate (or Maryland	•	rtificate of				Reg. No.	(010	40131
Physician		ne (First, Middle,Last))					2. Date of De	eath	Year	3. Time of Death
Medical Examine	oames n								er 3, 2010		1040 hrs
		if not institution, give	street and number)	44	Edgewoo	n, or Location of De od	ath	Hari	ounty of Death ford	
Funeral	5. Social Security I		7. Ac	ge (In yrs. I	ast birthday)	If Under 1		Hrs. 8. Date of I	Birth (MM/DD/		hplace (State or
Director	220-33-7 Usual Residence of		{ M 2 F		33 Yrs.	Months	Days Hours I	Oct.	7, 197	77 Foreig	n ^{untry)} MD
any	10a. State	10b. County		10c. City	, Town or Locatio	n					10d. Inside City Limits
Maryland 28a-f show d at once.	MD	Harford		Abe	erdeen						1 X Yes 2 No
the Maryland a or 28a-f sh tifted at once Director	10e. Street and Nu					10f. Zip Coo			10g. Citizen	of What Cour	ntry?
vith the 23a o 23a		h Chapel F	d . 12. Was Deceden	t Ever in 11	S 13 Was	2100	1 f Hispanic Origin?	Specify Yes or N	USA In- I14	Race - Ameri	can Indian, Black,
r death with the Maryland or items 23a or 28a-f sho must be notified at once. Funeral Director	1 Never Marri	ed 2 X Married	Armed Forces				uban, Mexican, Pue			White, etc.	,
safter cral", ol	3 Widowed		If Yes, Give Year or Dates:				No specify:				ite
hours hours Exam	15. Decedent's E Elementary/Sec	ducation (Specify onl	y highest grade cor College (1-4 or				upation (Give kind life. DO NOT use		16b. Kind	of Business/li	ndustry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	7	oridary (0-12)	College (1-4 of	3+)	Equipme	ent On	erator		Cor	struct	ion
5-00 led wit Hygien other the M. Con		(First, Middle, Last)			<u>г = qu = рик</u>	л ор		me (First, Middle			.1011
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Jimmy L	ynn Dills ame/Relationship(Ty	- Dist		40h Maillean	\	Doris	Davis		- T Ot-1-	To Oada)
, MD 21 and 2 should lealth and Me tem 27 is ma traumatic ev		Dills/ Wif			10	•	ton Rd.				. ,
e, MD 2 I and 2 shou Health and I Item 27 is n r traumatic	20a. Method of Dis	position			Place of Dispositi crematory or othe	on (Name of		Date 2/7/2010		ation - City or	
MOF Pages ient of int: If		Cremation 3 Other Specify:		ale	•		ral Home			ng Sun	, MD
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati		ineral Service Linens					ress of Facility	al Home			
Physician	23a Part I. Enter ti	ne disease, or compli	cations that caused	the death	Do not enter the	S O	rd Funer ueen St.	Rising	Sun M	D 2191 or heart	Approximate Interval
Medital	failure. List or	nly one cause on eac	h line. Contact Shotgu			,	3,				Between Onset and Death
xaminer	or condition resulti	_	ue to (or as a cons								
	Sequentially list co		ue to (or as a cons	eguence o	nft:						
i i	cause Friter Und	orlying Causa C					.			1	
cecuted recuted rand rand ransit	events resulting in		ue to (or as a cons	equence o	rf);						
. Box 68760, the death certificate be executed by the attending physician and ched for use as the burnal - transit Physician/Medical Examiner	UNPENDED		AMENDED								
760, cate be exe physician the burial -	IF FEMALE: 23b. Was decedent	progrant in the	23c. If yes, outco	me of preg	nancy					ate of delivery	
OX 6876 eath certifical attending ph for use as the	past 12 months		1 Live birth Pregnant at	t time of de	ath =	death (Specify)	3 Ectopic pre	gnancy	Mor	nth D	ay Year
Box e death c the atten ed for us	1 Yes 2	No 9 Unknown	9 Unknown								
P.O. E es that the d igned by the be detached		ificant conditions	contributing to deat	h but not r	esulting in the un	derlying cau	se given in Part I.			contribute to t	he cause of death? ably 4 Unknown
ords, Ewrequires s been sign should be oldered											opsy findings available
of Vital Records, ag Physician: The law require the this certificate has been signered director, page 2 should be n: To Be Completed								perl	opsy ormed?	death?	ompletion of cause of
tal Rection: The certificate ector, page		red to medical				26.P	lace of Death (Che	1 Yes	2 No	1 🗸 Yes	s 2 No
Vital Inysician:	examiner?	The second second	ospital: 1 Inpatie	ent 2	ER/Outpatient	3 DOA	Other ₄ Nu	sing Home 5	Residence	6 🗸 Other:	Scene
C = . ~ 4 5	27 Manner of Deat	th 5 Pending	28a. Date of Inju Month, Day Dec 3, 2010	ury (ear)	28b. Time of Inju 0000 hrs	ıry 28c. 1	Injury at Work? Yes 2 ✔ No	28d. Describe Subject sh		ccurred	
	2 Accident 3 Suicide	Investigation 6 Could not be	28e Place of Ir	njury - At h	ome, farm, street,	factory, offic	ce building, etc.			lumber or Rur	al Route Number, City
Divospital of hours at hours at y filled	4 Homicide	determined		rk/Recre	eation Area			or Town, 3200 Pulask	i Highway, I	Edgewood, I	MD
9 4 2 2 9 20		Certifying Physicia Medical Examiner:	On the basis of exa								
To the within To the comple	29b. Signature and		and manner stated.		·		ense number		_	signed (Mon	
	and	2				0.	C.M.E.		Decem	ber 4, 201	0
14		ress of person who co			•	not Dell'	imera MD 040	101			
	Ana Rubio		t Medical Exan	r's Signati	ILEA	eet, Balti	more, MD 212				
State Registra		חדתפייני	A Joz. Keyistia	o orginall	backer						

UUNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec. Day 2010 ear Physician/ John Ward Daugherty, Jr. 14 5:30 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Allegany Health Nursing & Rehab. Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Hours 1 🕅 M 2 □ F (Month, Day, 232-26-3806 Director 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertell Hygiene. Important: If time 27 is an arted other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director WV Mineral Keyser X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 182 D Street 26726 USA 12. Was Decedent Ever in U.S.
Armed Forces?

Y Yes 2 No
If Yes, Give 1717 T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married X☐ Yes 2 ☐ No If Yes, Give Year or Dates.WW II Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Gas Company Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Ward Daugherty, Sr. Lula P. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Daugherty/son 863 Park Place Drive, Virginia Beach, VA 23451 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation X ☐ Other (Specify) Scarpelli Crematory 12/15/10 Cresaptown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
Markwood Funeral Home, Hard Dec Inc. 23a. Part 1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, P.O. Box Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) MELL Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant □ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 | Tuxo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 7/2009

10-09444 Betty Dickerson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2	\cap		1		Û		0	(
6	U	j	J	A. P	U	Ł	0	1

			ertificate of Death	Reg. No.	O MOID
Physic Medical Exan		Decedent's Name (First, Middle,Last) BETTY DOLORES DICKERSON		2. Date of Death Month Day Year December 7, 2010	3. Time of Death 0000 hrs
		Facility Name (if not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	4c. County of Deat Montgomery	
Funera Directo		579-42-3461 1 M 2KF	7 6 Yrs. In International Inte	8. Date of Birth(MM/DD/YYYY) 9. Bit 10-12-1934 Forei	rthplace (State or gn WASH . , D .
and f show any	٥ .	Usual Residence of Decedent 10a. State	y, Town or Location FORESTVILLE		10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 7817 JORDAN PARK BLVD.	10f. Zip Code 20747	10g. Citizen of What Cou	untry?
after death wi	y Funer	11. Marital Status 1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If yes Give Year or Dates:	U.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-Rican, etc.) 14. Race - Ame. White, etc. Specify: WHI	rican Indian, Black,
11215-0036 Ide filed within 72 hours fental Hygiene. arked other than "natur vent, the Medical Exam	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)	16a. Decedent's Usual Dccupation (Give kind of w during most of working life. DO NOT use retin APARTMENT OWNER		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last) ALEX MARTIN DICKERSON	LILLIE	(First, Middle, Maiden Surname) MARIE BANKS	
MD 2 nd 2 shoul alth and N m 27 is m		19a. Informant's Name/Relationship (Type, Print) JAMES A. ANDREWS-SPOUSE	19b. Mailing Address (Street and Number or F 7817 JORDAN PARK B	LVD. FORESTVILI	E,MD.20747
Baltimore, permit. Pages I an Department of Hec Important: If ite injury or other tr		20a. Method of Disposition 1			RNIE, MD.
		29a. Part I. Enter the disease, or complications that Paused the deat	22. Name and Address of Facility RAYMOND FUNERAL LA PLATA, MARYLA	SERVICE, P.A. ND 20646	Approximate Interval
Physiciar /Medica :xamine	1	failure. List only one cause on each line.	s of Spinal Column Comp		Between Onset and Death
ed ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence c. Due to (or as a consequence			
760, icate be executed physician and the burial - transit	edical		t.II,27,28a-f per me g91	3 3-9-11 vt	
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be cleath. Extor: After this certificate has been signed by the attending physici by the funeral director, page 2 should be deached for use as the burit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pre	2 Fetal death 3 Ectopic pregnal	ncy 23d. Date of deliver	y Day Year
ires that the signed by the be detached	à	Part II. Other significant conditions contributing to death but not Chronic Obstructive Pulmona		23e. Did tobacco use contribute to	
Division of Vital Records, tal or Attending Physician: The law requirer as after death. **Al Director: After this certificate has been sifed in by the fineral director, page 2 should be led in by the fineral director, page 2 should be	plete	Congestive Heart Failure, Ch		24a. Was an 24b. Were au	utopsy findings available completion of cause of
Vital Rec ysician: The linis certificate director, page	Be	25. Was case referred to medical examiner? Hospital 1 Inpatient 2	26.Place of Death (Check of De		
ion of Vitending Physicath. For: After this the funeral dir	l ii	27. Manner of Death Natural X Accident No No No No No No No No No N		28d Describe how injury occurred subject was a pas vehicular rollove	senger in a
Division To the Bospital or Attend within 24 hours after death To the Fuoeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	ijor road	28f. Location (Street and Number or Ruor Town, State) Rte. 50 Wicomico Co., Md.	, Salisbury
thin 24 or the Fu	edical	(Check only one) 2 Medical Examiner: On the best of my knowled one) and manner stated.	dge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred at		
	Me	29b. SignarCire) and title of certifier Orleans	29c. License number O.C.M.E.	29d. Date signed (Mo December 9, 20	
		30. Name and address of person who completed cause of death (Iter Laron Locke MD. Assistant Medical Examiner		01	
S Regis	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signal	ure A haved		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edith Rebecca Eskridge December 2010 12:05 pM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester Chesapeake Woods Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Funeral (Month, Day, Ye Days Gountry) Marvland Months Hours Min 1 M 2 X F 90 222-12-3825 Director 1920 Usual Residence of Decedent or 28a-f shov 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Examiner must be notified at Director Cambridge MD Dorchester 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21613 USA 318 East Appleby Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Force Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. ō ģ 1 X Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) hospital 2 should be filed with h and Mental Hygien 7 is marked other th 11 registered Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lottie Ellis Ernest B. Eskridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trans 318 E. Appleby Ave., Cambridge, MD Ralph A. Eskridge brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State Crematory of Delmarva 12/3/10 Delmar, DE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. Cambridge, MD 21613 700 Locust St Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exam burial-transi The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performa this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner. On the basis of examination and succession of the basis of examination and succession of the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

State

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ JOHN GIBBE EASTBURN DEC. 8, 2010 10:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death CHARLES 3047 B OCTOBER PLACE WALDORF Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Months Days Hours 1**X** M 2 □ F 90 MARth. 4", 4920 577-20-3956 WASH. D.C. Director Usual Residence of Decedent or 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD. CHARLES WALDORF 1 🗌 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3047B OCTOBER PLACE 20602 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Imped Forces? ARMY Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify WHITE If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry GAS "STATION ATTENDANT Elementary/Seconday (0-12) 5th College (1-4 or 5+) SWAIN GAS STATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN GIBBE EASTBURN, SR. ELSIE MINOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3047B OCTOBER PL. WALDORF, MD. 20602 CAROL ANN HALL-NIECE 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Department of H Important: If ite Date 1 X Burial 2 Cremation 3 Removal from State MD CVETERANS OTCEME) 12-20-10 CHELTENHAM, MD. 4 ☐ Donation 5 ☐ Other (Specify) M@0479 21. Signature of Funeral Service Licens any. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Physician. Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the cause (Disease) Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe After this certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 **X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

within 2

ause_of death (Item 23a) (Type, Print)

32. Registrar's Signature

OW LINE CENTER WALDONE AND 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Frank December 2010 Steven L. 6:33 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Assisted Living Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2□ F 59 Jan 9 220-46-1690 1951 Washington, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Experiment must be retified at appres. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🙀 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 United States 101 Kerwin Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates: Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Architectural Draftsman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma Landau Charles Frank ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelton, CT 401 Papere Ridge. 06484 Harold Frank, brother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdn | 12/6/2010 Olney, Maryland 4 □ Donation 5 □ Other (Sperity) 23a rt1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, since cause the death. Lung Cancer and Lung Cancer a 22. Name and Address of Facilithines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury Examiner Due to (or as a consequence of) Cause (Disease of inju-that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) P.O. Box 68760. Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 🗆 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Other Act Living 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Certifier Medical (Check only one)

of Vital Records. Division e Funeral within 2

> State Registrar

29b. Signatur

Nick Farrell,

31. Date filed (Month, Day, Year)

29c. License number

67258

9707 Medical Center Drive, Rockville, MD 20852

29d. Date signed (Month, Day, Year)

December 4, 2010

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#17-19a, per INF, G913, 3/28/2011, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Miguel Angel Iginio 2:35 Dec. Flores 1 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death P.G. Hospital Center Cheverly . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year
Aug 1, 1 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Days Min. Country) El Salvador 1 **₹ X**1 2 □ F Months Hours 216-98-9328 Director Yrs 56 Aùg 1954 Usual Residence of Decedent 28a-f show 10a. State with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 21 No md Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9606 McAlpine Road 20901 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036
Final: Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", on any injury or other traumatic event, the Medical Exami If Yes, Give Year or Dates 1 🕱 Yes 2 🗆 No Specify: Salvadorean 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 Fo<u>od Distributor</u> Food Service Be Precila Name (First, Middle, Maiden Surname) Miguel Rigel Flores Bonilla ၉ Priscilla Osorto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901 Cecilia Carmen Flores/Wife 9606 McAlpine Road, Silver Spring, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gate of Heaven 1 X Burial 2 Cremation 3 Removal from State Dec. 2010 4 ☐ Donation 5 ☐ Other (Specify) Gate Silver Spring, 21. Signature of Funeral Service Licenses Plane and Address of Facility lins Funeral Home Inc. 500 University Blvd. W., Silver 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Que to (or as a consequence of): Examiner contrale Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown been Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 2. No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural injury 5 Pending 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide 2 No Investigation npleted filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

(Check only one)

29b. Signature and the of e

Name and address

31. Date filed (Month, Day, Year)

6

3

ompleted cause of death (Item 23a) (Type, Print 3001

Registrar's Sigr

Davis

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

D63688

29d. Date signed (Month, Day, Year) 3

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2010 9:10 Frank M. Freeman ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Harmony Hall If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1 🔀 M 2 🗆 F 07/15/1918 300-05-4160 92 Ohio Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
In the 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Columbia 1 Yes 2 XNo MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 United States 6336 Cedar Lane Apt. 234 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Scott's Grass Seed Maintenance Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Kenyon Allen Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Clarksville, MD 21029 Merrillyn Hill - daughter 11200 Joan Marie Court injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Kemoval from State Africa Orange Cemetery 12/09/2010 Lewis Center, Ohio 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Lice more M00845 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No the g | Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6- Other (Specify) 4551'540 Livie 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1- 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 of person who completed cause of death (Item 23a) (Type, Print) Suite 103 (olumbia MD Zloty Name and add 84 Lane 31. Date filed (Month, Day 32. Registrar's Signature State eneur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November ^D3y0, 20°1'0 10:55 A M Goodman Medical Bettye 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hebrew Home of Greater Washington Rockville 5. Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Hours Mir Washington, DC 578-20-7144 **Director** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Funeral Director 28a-f 1X Yes 2 □ No Rockville Maryland Montgomery 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a 20852 1801 East Jefferson Street #326 be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ō 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Specify: 3 - Widowed 4 - Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Maurice Stearman May Marks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 1801 East Jefferson St, #326, Rockville, MD 20852 Daniel J. Goodman, husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
King David
Memorial Gardens 1X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/02/2010 Falls Church, Virginia 21. Sign o Funeral Service Licenses DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. M01255 1170 Rockville Pike, Rockville, Maryland 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and a for use as the burial-trans To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 No 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Frantianer: To the basis of my knowledge death occurred at the time, date and due to the cause(s) and manner stated Gertifying Nurse Frantianer: To the basis of my knowledge death occurred at the time, date and due to the cause(s) and manner stated within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00648

State Registrar Montrose

6105

2. Registrar's Signature

Rockville,

Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fazl

06

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Mo}Dec 13, 2010 ear 0550 William Grabenstein George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Co. Nurs. and Rehab. Ctr. Allegany Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months Days Hours Min Nov 27 Director 220-16-7099 87 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Bedford Bedford 1 □XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 851 Bedford Valley Road 15522 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) 12 College (1-4 or 5+) Railroad clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Linnie Belle (Adams) Grabenstein George A. Grabenstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 851 Bedford Valley Road Bedford PA Mildred Grabenstein 15522 . Page 1 and 2 sh tment of Health a tant: If item 27 is wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite injury or (sunset Memorial Park 1 X Burial 2 Cremation 3 Removal from State 12/15/2**d**10 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) Signatury of Funer / Service Licensee 22. Name and Address of Facility eral Home, PA any 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to for as a consequence of: **Examiner** NI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death signed by the a d be detached for 1 ∐ Yes 2 L 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, icate has been sig 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No Yes director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Aursing Home 5 - Residence 6 - Other (Specify, 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Acciden
Suicide 5 \square Pending injury 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registr

GUPTA M.D

31. Date filed (Month, Day, TEC 2

33280

AVENUE CLIMBERLAND MD

13

20/0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jennie Alexander Hodgson P^{M} November 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Maryland (Month, Day, Year 1 M 2XXF Days Hours 397-32-1716 **Director** 80 1930 Nov. Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 XYes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 930 Bay Forest Court, #320 21403 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 ₩idowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Educator Education 5+ Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filled Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Lyle Thomas Alexander Helen Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $P \cdot O \cdot Box 558$ Lunenburg, MA 01462 Lyle Hodgson/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2XX Cremation 3 🗆 Removal from State Baltimore Crematory 12/2/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Ineral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final Priysician (or as a consequence of): disease or condition resulting in death) Medical Due t **Examiner** Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Pregnant at time of death Month Day Year signed by the a d be detached f Yes 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ils certificate has director, page 2 autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann funeral Certificate: eath 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 2 Accident
3 Suicide
4 Homicide ours after death.

leral Director: A
filled in by the fu 1 Yes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00

32. Re

Goulet

31. Date filed (Month, Day, Year)

1 - For Amended #99per fn, RG FGHD 12/10 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Combo PATRICIA ANN HARRIS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HAGERSTOWN WASHINGTON WASHINGTON COUNTY HOSPITAL Social Security Number 7. Age (In yrs. last birthday) 65 Yrs. If Under 1 Year If Under 24 Hrs. 6 Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 M 2 M F 12977 74 7944 217-44-5431 ENGLAND **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No WASHINGTON BOONSBORO MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 141 SOUTH MAIN STREET 21713 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) 72 during most of working than Elementary/Seconday (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traument. College (1-4 or 5+) HOUSEWIFE DOMESTIC 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 DORIS IDA MAE HILLING WILLIAM D. HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES VAUGHN / SON 11010 LINCOLN AVE., HAGERSTOWN, MD 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/09/201 BURTONSVILLE, MD UNION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility P.O. BOX 86 BARNESVILLE, 0 HILTON FUNERAL HOME MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ BILATERM NEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner OF DIS ABLIME YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ENAL FAILURE AL CIMONIC and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
g Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) page 2 should be detached g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Dunknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 2 × No Yes 2 YN Be 25. Was case referred to medical completed filled in by the funeral director. 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA မြ 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural iniury work?
1 Yes 2 No 5 Pending s after death 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4656 06 MO 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

ATOWA

Ken

21740

MU

HAGOUTOWN

1190

-32. Registrar's Signature

Menderica

MI

8mp 12

H172ach

31. Date filed (Month, Day, Year,

10-09244 Terry Lee Hostler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 3. Time of Death Month Day December 1, 2010 **Medical Examiner** 1921 hrs Terry Lee Hostler 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11531 Windsor Road liamsville Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Washington Country) D.C. Months Davs Hours Min Director 1 XM 2___F 212-54-6518 61 1949 Sept. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Frederick Ijamsville Pages 1 and 2 should be filed within 72 hours after death with the Maryland rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 11531 Windsor Road 21754 U.S.A. Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: White ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12 Mechanic Oil Burner 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental | Important: If item 27 is marked njury or other traumatic event. Be George W. Hostler Charlotte Burkett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ijamsville, Maryland Barbara A. Hostler - Wife 11531 Windsor Road, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify Metropolitan Crematorijum 12/04/10 Alexandria, Virginia 21. Signature of Funeral Service License Name and Address of Facility Molesworth-Williams P.A., Funeral Home Krun llam 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea 20872 **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Cisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive atherosclerotic cardiovascular disease Completed page 2 should certificate has been 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25 Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene After this 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Subject fell striking head FOUND: 1 Natural 5 Pending 1 Yes 2 ✔ No within 24 hours after death To the Funeral Director: the Dec 1, 2010 1910 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 11531 Windsor Road, Ijamsville, MD determined (Specify) Residence 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 2, 2010 30. Nane and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registra

31. Date filed (Month, Pay, Year)

OCME

acker

32. Reistrar's Signature

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 HEDGES, PALPH Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and \text{\completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Physicia /Medic Examin

State of Marylan		artment of He rtificate of D			ene	10	40150
Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death			3. Time of Death
Ralph Edward Hedges			+	Decembe	r 5 .	Year 2010	4:00A M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I		Jeceni De	4c. County		7.007.
Western Maryland Hospital Cente	Hagers	town		Was	hingt	on	
5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear)	9. Birthpl	ace (State or Foreigr
219-46-1295 ¹ √ ^M ² □ F 65	Yrs.	Months Days	Hours Will.	6/11/194		Mary	
Usual Residence of Decedent							
10a. State 10b. County 10c. Cit	y, Town or Lo	ocation				10	0d. Inside City Limits 1 ☐ Yes 2 No
Maryland Washington Hag	erstow	n					
10e. Street and Number		10f. Zip Code		100	g. Citizen of \	What Count	try?
21915 Holiday Dr.		21783			J.S.A.		
11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of His If Yes, specify Cubar	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	
1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 📉 No	Specify:		Specif		
3 ☐ Widowed 4 ☑ Divorced Year or Dates:	I 40: D.		V	T 4	Ch Kind of D	Whit	
15. Decedent's Education (Specify only highest grade completed)	Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of worki	ing "	6b. Kind of B	uşiness/ind	iusiry
Elementary/Secondary (0-12) College (1-4or 5+)	1				M	odłoo.	1
17. Father's Name (First, Middle, Last)	гото Т	<u>Cechnician</u>	18. Mother's Name	(First, Middle, Ma		edicai ne)	L
·				,		,	
Ralph Calvin Hedges 19a. Informant's Name/Relationship (Type. Print)	19h Mailii	ng Address (Street a		Weidman		State. 7in	Code)
, , , , ,	1	•					,
,		resson Dr			Oc. Location		
1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State	cemetery, cre	matory or other place	i i	ŀ		•	
	thsbur	g Cremato	ry 12/8/	/2010 Sn	nithsbu	irg, l	Maryland
21. Sign u re I Funeral Service Consee		2. Name and Addres					-
23a. Part1. Enter the disease, or complications that caused the deat		601 Penns				1 Mary	YLANG Z1/4 Approximate
shock, or heart failure. List only one cause on each line.	in. Do not en	ter the mode of dying	, such as cardiac	The respiratory arres	,		Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	nall Cell Carcinoma with metast				ASIS	Λ	nouths
Due to (or as a conseq	to (or as a consequence of):						
Sequentially list conditions, if any leading to immediate Due to (or as a consequent		obacco 1	Dersenden	a	1/ lar		1/ ears
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1001100 01).			7.5		18	/
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							·
d							
IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregn.	ancy				23d. Da	ate of delive	erv
235. Was deceded the program of the past 12 menths? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of the past 12 menths?		□Ectopic pregnancy □ Other <i>(specify)</i>				onth	Day Year
9 ☐ Unknown							
Part II. Other significant conditions contributing to death but not res	sulting in the u	ınderlying cause give	n in Part I.	23e. Did toba	acco use con	tribute to th	ne cause of death?
Hypertension				1 ☐ Yes	s 2 No	3 prob	abiy 4 Unknow
	-			24a. Was an	24h	Were auto	psy findings availabl
				autopsy	red?	prior to cor death?	mpletion of cause of
OF Was aggs referred to an alice!			00 BL :-	1□ Yes 2	No	1 ☐ Yes	2 2 No
25. Was case referred to medical examiner? Hospital: Hospital:	I CD/O: # "	nt 3CLDOA Othe	r·	h (Check only one			,
1 ☐ Yes 2 ☐ No 1 ☐ X Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	ER/Outpatie	III OLI DON	4 Li Nursing no	me 5 Resider 28d. Describe hov		. , ,	γ)
1 Natural 5 Pending (Month, Day Year)	Injury	Work	? ′es 2□No		,31, 00001		
3 Suicide 6 Could not be 280 Place of injury. At h	ome. farm. st			28f. Location (Stre	eet and Num	ber or Rura	al Route Number.
4 Homicide determined building, etc. (Speci	fy)	,,		City or Town,	State)		
29a. Certifier 1 Pertifying Physician: To the best of my know	owledge, deal	th occurred at the tim	e, date and place.	and due to the ca	use(s) and m	anner as s	tated.
(Check only one) 2 Medical Examiner: On the basis of examination one) and manner stated.							
29b. Signature and title of certifier		29c. License	number	29	d. Date signe	ed (Month,	Day, Year)
monica Squllworth, M)		> -			12/6		
	m 22a\ /T	5	064911			/	
30. Name and address of person who completed cause of death (Iter Mornica Stallworth, MD	m∠oa) (Type,	100		lvania Av MD 21742			
D4 Date filed (Month Day Year) 22 Pegietrar's Sign	ature		erarowii,	TID 21/4	۷		
OEC 0 7 2010	1 1	age to					
-	1" 15						

Sta Registr

P.O. Box 68760, Division or Vital Records, To the Hospital o within 24 hours aft To the Funeral D

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

se of death (Item 23a) (Type, Print) M321 BLOOMINGD ALK

State Registrar

filled in by

completely

31. Date filed (Month, Day,

DEC 08 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . Year Day Physician 3, Charles R. Hilaman 2010 6:20p M December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Cecil E1kton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1**X** M 2 □ F 220-26-8218 91 June 10. Director PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ir than "natural", or items 23a or 28a-f shov the Modical Examinar must be notified at 1 ☐ Yes 2 1 No Director Cecil Rising Sun 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a 21911 866 Lombard Rd. USA Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trauments. Elementary/Secondary (0-12) 12 College (1-4or 5+) Mobile Milling/Feed Dealer Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ester Crowl Norman Roston Hilaman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 Tome Hwy. COlora, MD 21917 Jim Hilaman/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oxford Cemetery 12/8/2010 Oxford, PA 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A 111 S. Queen St. Rising Sun, 21. Signature of Funeral Service Liga 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (inal disease or condition resulting in death)

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed' certificate 2 No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

le Funeral Director; A
bletely filled in by the fi 2 Accident 6. ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760 Division of Vital Records,

Baltimore, Maryland 21215-0036

State Registrar

completely

the

0

29a, Certifier

(Check only one)

29b. Signature and title of certifier

11) hoch

Medical

Rajal 106 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 07 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

EIKton Mb 21921

29d. Date signed (Month, Day, Year)

2/3/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 2010 10:15A Shirley Laurine Jones Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 933 Edgewood Rd. Apt. 116 Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Hours 6/6/1928 ear Director 214-26-3123 82 MaryTand Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tifew 27 is marked of other than "natural", or items 23a or 28a-f show ant if item 27 is marked of when than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland | Anne Arundel 1 🌠 Yes 2 🗌 No Annapolis 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 933 Edgewood Road Apt. 116 21403 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Specify Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Contract Officer Dept. of Navv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilford Emmet McCarthy Della Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Holleran/Daughter 933 Edgewood Rd. Apt. 116 Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hillcrest Cemetery 12/6/2010 Annapolis, Maryland of Funeral Service License 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home ak 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease or complication: that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. shock, or heart failure. List only one caus Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury cate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 22 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy (unper performed? Yes 2 No Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital 2 No Other: ြု 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 2 Thomas

Registrar DHMH 17 Rev 7/2009

State

Maria

MARIA E. ROMERO

31. Date filed (Month, Day, Year)

DEC 0 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

122

M.D

32. Registrar's Signature

Depense Highway Suite 200 Arrapolis, Md 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11/30 2010 Year 10:15 ам Wilda Moore Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Solomons Nursing Center Solomons Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours Min. 1 M 2 X F July 3, 1918 ^{Cou}Mississippi Director 579-58**-**6139 92 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Examiner must be notified MD Calvert Dowell 1 Yes 2 X No ō 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a Funeral 580 Twin Cove Lane 20629 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Broker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) G.E. Moore Hester Stringer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Golden/Daughter P.O. Box 115, Dowell, MD 20629 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 5 1 X Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 12/04/2010 Brentwood, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Pregnant at time of death signed by the at d be detached for 1 ☐ Yes ∠ ☑ 9 ☐ Unknown Part II. Other significant conditions contriguting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an Were autopsy findings available autonsy prior to completion of cause of death? 2 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item, 23a) (Type, Registre State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Eskeline Adams Jones 2010 2 Dec. 3:45 а Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery Social Security Number 8. Date of Birth Date of Billing (Month, Day, Year 3 0 Funeral 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 1 M 2 X F Months Davs Hours Min. Director 400-20-674 90 1920 Nov. Usual Residence of Decedent show 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f sl 1 ☐ Yes 2 X No MD Montgomery Silver Spring 'n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral Interlachen Dr., 15100 #1009 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 № Specify: 3 Widowed 4 ☐ Divorced White "natural" Completed Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home other traumatic event, Be . Page 1 and 2 should be filed trnent of Health and Mental Hy tant; If item 27 is marked ott 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eskel Adams Maude Elizabeth Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Jones/Son 1515 Village Green Dr., Woodbine, Md 21797 Baltimore, t; If item ? 20a Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H 20c. Location - City or Town, State Date cemetery, crematory or other place)
Parklawn Memorial
Park Dec. 6 2010 1 M Burial 2 Cremation 3 Removal from State Rockville, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francisco Facility Ilins Funeral Home 500 University Blvd. W., Silver Spring, MI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Atheroxcleratio carrioviscular Medical Due to (or as a consequence of): Examiner calesa Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clearth.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transt attending physician and for use as the burial-transit 4ypotensim that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Natural iniury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 039792 20 completed cause of death (Item 23a) (Type, Print) Christophes J. Mays 1314 Prince Philip Drive, Olney, up 20832 ims

State

Registrar

31. Date filed (Month, Day, Year)

06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 19b per FH C910 12/20/10 dk
State of Maryland / Department of Health and Mental Hygiene 2 [] 40156 State
Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 20110 EDNA MARIE JORDAN Dec PM 4:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2630 Hess Road Fallston Harford Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 F Days Months Min. Month Day, Hours Virginia Director 216-28-275] 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD. Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2630 Hess Road 21047 United States Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. 1 \square Never Married 2 \square Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🕅 Widowed 4 🗆 Divorced If Yes, Give White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Electronic Parts Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturer Electronic Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Boyd Jones Jefferson Martha Ida 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17314 Delta, (Son 104 Forest Pennsylvania James B. Jordan Jr. Rrail 20a. Method of Disposition Date 17, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2010 Mem Gardens Fallston, Maryland 21. Signature of Fune of by rvice Ligensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral W Jarrettsville, Maryland Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the cause of the death. Approximate Interval Between and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examiner Due to (or as a nonsequence or, if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DOGKINS 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes . Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 1 No ☐ Yes Yes 25. Was case referred to medical Be **Director:** After this certific 26. Place of Death (Check only one) Hospital: Other: 2 🗹 No ၉ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Sian and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30133 12/13/2010 d address of person his completed cause of death (19m 23a) (Typ) Print) THEMIX MD ZII31 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROGER NORMAN KIMBLE, SR. Month Year 9:14PM DECE MIER 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death APlata IVISTA MEDICAL CENTER Charles 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Mountry) **Funeral** 214-48-6135 1 X M 2 □ F Days Hours Mir Months 6 Mo 5h_ Day 9 497 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD. ST.MARY'S MECHANICSVILLE 1 🗆 Yes 2 🔀 No 10f. Zip Code 20659 10e. Street and Number 10g. Citizen of What Country? Funeral 30165 CURTISS ROAD U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces $egin{array}{c} egin{array}{c} egin{array}{c} egin{array}{c} oldsymbol{\mathsf{ARMY}} \ oldsymbol{\mathsf{Z}} oldsymbol{\mathsf{TNAM}} \ oldsymbol{\mathsf{VIETNAM}} \ \end{array}$ þ 1 Never Married 2X Married WHITE 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) CHOPP & CO. MILL WORKER 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLARICE MAY DEAN TRA JAMES KIMBLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MECHANICSVILLE, MD. 20659 ROGER N. KIMBLE, JR. - SON 30165 CURTISS RD. Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State MD. VETERANS CEM. 12-22-10 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature Juneral Service Licenses AYMOND FÜNERAL SERVICE, P.A. A PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Ph_sician/ disease or condition Medical Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Let Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Inpatient 1 🗌 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending Accident Investigation Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 Ccertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the casis or examination alrevolutive sugation, it my examination as the state of the case of the cause of the c 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 57708 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 C OFFICERD OMAIS WALDERF, MARYLAND 31. Date filed (Month, Day Year) 32. Registrar's Signature State GREN-AN Registrar

DHMH 17 Rev 7/2009

OGER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a,f per me. 2910,12/17/2010dhb Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER WILLIAM M. KNIGHT, SR. 2010 AM 5:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **OUEEN ANNE** CENTREVILLE QUEEN ANNE COUNTY HOSPICE CENTER 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Funeral 6. Sex 7. Age (In vrs. last birthday) Months Min 1 X M 2 🗆 12-5-1928 PA Director 183-30-9643 81 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Queen Anne's Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 520 Sheriff Meredith Rd. 21620 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 White If Yes, Give Year or Dates, 1951–1956 1 ☐ Yes 2 XNo Specify. Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Clifford Knight Anna Marrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chloe E. Knight/Wife 520 Sherriff Meredith Rd. Chestertown, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sudlersville Cemetery 11-13-2010 Sudlersville, MD Si mature of Funeral Service 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, MD 21620 Pay 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. he death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Traingri 72 WEZZ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause Enter or derlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): burial-transi CERTIFICATION APPROVED BY attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should CEREBOVAGESTON ALLIDENT 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? After this certificate 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be HOSPICE CENTER examiner? Other: 4 Nursing Home 5 Residence 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural $5 \square$ Pending work? 1 ☐ Yes Accident 2 No Sph Investigation after death 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number of Bural Route Number, 520 Sheriff Chestertown, MD within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 63747 11/8 10

Registrar
DHMH 17 Rev 7/2009

State

Cen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Contrent

NOV

25 40 _ (e~)
31. Date filed (Month, Day, Year)

UKENSMD

JEFFREY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 JOLLY HAROLD KITTS, JR. DEC.8, 7:42 РМ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10506 BEECHWOOD DRIVE CHARLES WALDORF 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 D F VA untry) 1/20nt/0 1/2 Y1a9 4 9 212-52-4093 61 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Director be notified MD. CHARLES WALDORF 1 ☐ Yes 2 🕅 No 5 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 10506 BEECHWOOD DRIVE 20601 U.S.A. must t filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? 1 X Yes 2 ☐ If Yes, Give Black, White, etc. 0 by 1 Never Married 2 Married 2 INNAVY Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecifyWHITE "natural", 3 Divorced Completed Year or Dates al Hygiene. d other than "natura event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CARPENTERS UNION UNION CARPENTER 12th ulth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o ပ JOLLY HAROLD KITTS, SR. JOAN TROBRIDGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code IRENE M. KITTS-SPOUSE 10506 BEECHWOOD DR. WALDORF, MD. 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD. VETERANS CEM. 12-21-10 CHELTENHAM, MD. 4 ☐ Donation 5 ☐ Other (Specify) M004 AYMOND FUNERAL S A PLATA, MARYLAND . Signature of Funeral Service Licensee SERVICE, P.A. ND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each list Immediate Cause (Final Physician/ Ma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No jo 5 Other (specify) Month Year Dav Pregnant at time of death the detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has performed? Yes 2 No 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ြု 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of s after death. I Director: After t Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural N 5 Pending 1 🗌 Yes 2 🔲 No Accident Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after c Funeral Direct completed filled in by 4 Homicide determined Hospital Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number

DHMH 17 Rev 7/2009

DIL

State Registrar 30. Name and address of pe

31. Date filed (Month, Day, Year,

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sang Pil Lee 11:39xam November 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 8. Date of Birth **Funeral** Months Days Hours May 10. 1 🗆 M 2 🗶 F South Korea Yrs. <u>546-65**-**0</u>744 **Director** 88 Usual Residence of Deceder with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Frederick 1 Tes 2 X No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral U.S.A. 3728 Seward Lane 21704 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced Asian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sam Hee Choi Yoo Yul Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3728 Seward Lane, Frederick. Maryland 21704 Young Ki Lee - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 12/07/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Vo 11800 New Hampshire Ave., Silver Spring, MD 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it only one cause on each line. 23a. Part 1. Enter the diseasthock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Bronchospasm / Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Due to (or as a consequence of): the attending physician and the for use as the burial-trapsit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months? Day Month Year 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Alzheimer's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 No 1 Yes Yes within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan R. Segal.

06 2010

31. Date filed (Month, Day, Year)

OEC

M.D.

D52261

(500 Forest Glen Road, Silver Spring,

November 30. 2010

Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:56 A M William T. Larrick ECEMBER Medical 13 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Apr. 20, 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Days Hours Country) 213-26-0365 Director Yrs. 81 VA Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD White Hall Baltimore 1 Yes 2 X No ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a or Examiner must be Funeral 1310 Hicks Road 21161 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1951 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. I o**ther than** " Paper Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Manufacturing is marked other Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, should be file ည Kinzel Larrick permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic o Pearl Womeldorph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen J. Larrick/Wife 1310 Hicks Road White Hall, MD 21161 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery cremator or other place) ULaney Valley emorial Gardens Dec. 1 2010 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 21. Signature of Funeral Service Licensee J.J. Hartenstein Mortuary, 22. Name and Address of Facility Inc. 24 N. Second St., New Freedom, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit MYOCARDIAL INFARCTION Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be ARTERY DISTASE Division of Vital Records, P.O. Box 68760 the SS IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Por in the past 12 months? Month Day Year Yes 2 No detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ISCHEMIC CARDIOMYOPATHY or Attending Physician: The law requires 3 ArProbably 4 ☐ Unknown 1 Yes 2 No page 2 should RENAL INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No LACTIC ACIDOSIS certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) funeral nours after death. neral Director: After the filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital (24 hours a 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

29b. Signature and title of certifier

KICHARD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINTHICHM

M.D

Registrar's Signature

Comme

29c. License number

D 31826

7601 OSLER DRIVE TOWSON, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 23a per me, g911,01/12/2011dhb.

Certificate of Death

Reg. No. For State Registrar Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary E. McKenzie 2010 November 22:57 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shock Trauma Medical Center Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Ye OCt • 21, Birthplace (State or Foreign Country) **Funeral** Year) - 1<u>918</u> Days Hours 1 □ M 2 😾 F Months 199-07-6559 92 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland Director 10a. State 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Arnold 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Howard Avenue 21012 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 K No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any righty or other traumatic event, the Meany righty or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Healthcare Provider Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bruce Alexander Robertson Carrie E. Lehman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23155 Grove Road Preston, MD 21655 Michael McKenzie/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State Dec. 1 cemetery, crematory or other place, Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Rarranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Head Injury with Complications Approximate Interval Between et and Death 6 days Immediate Cause (Final Physician Subarachnoid disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to for as a consequence on Myocardial Infarction the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death Month Day Year the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary Edema 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy perform 1 Yes 2 No Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 X Yes 2 □ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: After 1 28c. Injury at 28d. Describe how injury occurred 1 🗌 Natural 11/19/2010 5 Pending iniury work? 1 ☐ Yes 2 🔀 No the Funeral Director: After the American After the Funeral Director After the Funeral filled in by the funeral 2 Accident unknown Investigation Fall Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 101 Howard Ave. Arnold, MD 21122 Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

(Check only one)

29b. Signature ar

31. Date filed (Month)

3

Stump MD

Year)

-22010

DEC

30. Name and address of pers

MD

Rept Surgery

who completed cause of death (Item 23a) (Type, Print)

29

S. greene st

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Battimore

29d. Date signed (Month, Day, Year)

2010

01

2/20/

29c. License number

1678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ December 2130 P M Doris Roberta Medairy 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) (Month, Day, Months Davs Hours Min Director 215-58-8460 79 June Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25901 Ridge Manor Drive 20872 USA death ' 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? hours after þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Shipley Frank Helen Hilton Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Jacqueline A. Hamersley/Daughter 13461 Long Days Court, Highland, MD 20777 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other place)
Damascus
Methodist Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dec.8,2010 Damascus, Maryland 21. Signature of Fundament Service Licensus 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Ventricular Fibrilation disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Mitral Valve Disease Years Securation list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Cause (Disease or linjury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a, Was an has performed? ☐ Yes 2 No this certificate 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certificate: To 1

✓ Inpatient 2

ER/Outpatient 3

DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🗹 Natural injury 5 Pending ☐ Accident ☐ Sulcide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29c. License number D0069427 December 3,2010 MΟ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 5801 Smith Avenue, Baltimore, MD 21209

Suite 3220

Kiemanh Pham,

31. Date filed (Month, Day,

MD,

's Signature

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FUI	partment of Health and Mental ertificate of Death	Hygiene Reg. No. 2010 40164				
	ysicia		1. Decedent's Name (First, Middle, Last)	2. Date of Month	of Death 3. Time of Death				
	ledic amin	er	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore City	4c. County of Death Baltimore				
Fund Direct			5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 □ M 2 💢 F 78 Yrs.	y If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month 1 2 -	of Birth h, pay, Year) -11-1931 S. Birthplace (State or Foreign MD				
faryland show	d at	'n	Usual Residence of Decedent 10a. State 10b. County MD Washington 10c. City, Town or Hagers		10d. Inside City Limits 1 ☐ Yes 2 ※ No				
with the Ma or 28a-	be notifie	I Director	10e. Street and Number 11104 Mimosa Court	10f. Zip-Code 21740	10g. Citizen of What Country?				
d 21215-UU36 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show	any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give If Yes, Give Year or Dates:	J. Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes ※☐ No Specify:					
Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or	Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) (Gh Elementary/Secondary (0-12) College (1-4 or 5+)	redent's Usual Occupation le kind of work done during most of working DO NOT use retired) Clerk/cook	16b. Kind of Business/Industry deli restraunt				
aryland 27 should be filed w nd Mental Hygier marked other t	c event, the	To Be Co	8th grade 0 17. Father's Name (First, Middle, Last) James Edward Burton	18. Mother's Name (First, M. Annabelle	iddle, Maiden Surname) Hamann				
and 2 shou ealth and M	er traumati		19a. Informant's Name/Relationship (Type. Print) Patrick Murphy son P.O	illing Address (Street and Number or Rural Route N BOX 171 11 N Mill	St. Clear Spring, MD				
IMOre, Pages 1 anent of He	ury or othe		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition Semitins.	position (Name of ematory or other place) Dec. Date 7, 2010	20c. Location - City or Town, State Smithsburg, MD				
Balti permit. Departn Imports	any inj once,		21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not e	22. Name and Address of Facility Donald Edwin Thompso P.O.BOX. 310 Clear St	on Funeral Home, Inc				
Physic //Medi		9 9	Immediate Cause (Final disease or condition a		Approximate Interval Between Onset and Death				
Exami	ne burial-transit	dical Examiner	Sequentially list conditions, from the conditions and the conditions of the conditio						
death certific e attending p	(7)	Physician/Me		□ Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year				
us, r.C ires that the signed by th	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
The law requate has been at	N	Completed			Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				
on C		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 1 ☒ Natural 5 ☐ Pending investigation 2 ☐ Accident investigation 3 ☐ Suiside 6 ☐ Could not be	of 28c. Injury at 28d. Desc / M 1 Yes 2 No	Residence 6 ☐ Other (Specify) pribe how injury occurred				
DIVISION ital or Attending urs after death. ral Director: After	lled in by 1	OF	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Roucity or Town, State) 28f. Location (Street and Number or Rural Roucity or Town, State)						
To the Hospital o within 24 hours af To the Funeral Di	mpletely f	Medical	29a. Certifier (check only one) 1 ★ Certifying Physician: To the best of my knowledge, de (check only one) 1 ★ Certifying Physician: To the best of my knowledge, de (check only one) 2 ★ Medical Examiner: On the basis of examination and/or and manner stated.						
5 in to	8		▶ By	RES-000	December 5 2010				
5			30. Name and address of person who completed cause of death (Item 23a) (Typerson who completed c	600 North	Wolfe St, Baltimore, MD, 21287				
Re	Sta gistra	re l	31. Date filed (Month, Day, Year) 32. R/gistrar's Signature	haded					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Edward Kenneth Miller 2010 2:13 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10111 Melody Lane Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**XX**M 2 □ F Months Days Hours Min. JUIV 24,1927 ^C∘∜Trginia 227-22-5387 83 Director Usual Residence of Decedent 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10111 Melody Lane 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 15 X Yes 2 □ No 1945If Yes, Give Year or Dates. 1949 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 and 2 should be filed within 72 hours and if Health and Mental Hygiene. 1 ☐ Yes 2XXNo Specify. Specify: Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Land Right of Way Manager Utility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miller Frank Stanley Anna Julia Affleck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Schnebly-Daughter 14706 Fairview Rd. Clear Spring, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Hebron Cemetery Dec.7,2010 Winchester, Virginia 21. Signature of Funeral Sept Osborne Arunerality Home, P.A. 425 S. Conococheague St.Williamsport, 21795 23a. Part 1. Ent.: the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Part 1. Ent. The disease, or complications that begoes shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that better the cause of t Exam The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? g Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death. I Director; After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined

Registrar

Medical

(Check

SAMUEL CHAN, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANTEETAM SINCET.

32. Registrar's Signature

DHMH 17 Rev 7/2009

Selle 200.

🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Numer Practicals: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Dec. 2 2010

29c. License number

1)36655

threestown, MO 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Marv Isabelle Mowbray November 2010 6:45 pM Medical 4c. County of Death
Dorchester 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Chesapeake Woods Center Cambridge 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 □ M 2 🏻 F Months Min. Sept. 9 ^{Country)} Mary<u>land</u> Director 214-12-6393 95 Usual Residence of Decedent or 28a-f show 10a. State Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 525 Glenburn Avenue 21613 USA "natural", or items 23a 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irvin Wilkinson Laura May Street 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Calvin W. Mowbray Jr. 263 East Green Apt. 8, Westminster, MD son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Old Trinity Churchyard 11/30/10 Church Creek, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Congestive Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Stenasis Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 1 ☐ Yes 2 /2 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension, dementia, 1 Yes 2 No 3 Probably 4 Unknown Vascular accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 44 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rry opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

Box 68760

Records,

Division of Vital

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature ar

Dramble

Please Type or Print in Black Indelible Ink. Ensure All Copies Are State of Maryland / Department of Health and Mental Hygiene	Legible.	1010
State of Maryland / Department of Health and Mental Hygiene	2010	4010
Certificate of Death	Rea No	

		1- For State Registrar	, , , , , , , , , , , , , , , , , , ,	Certif	icate of Dea	ath		Reg.	No.	
Physici	an/	Decedent's Name (First, Michael Control of the					Mon	of Death	av Year	3. Time of Death
Medical Exami	ner	Ruth Ann 4a. Facility Name (if not institu		loran	Ab Cib.	, Town, or Location	Dec	ember 3	, 2010 4c. County of Dea	1323 hrs
		St. Mary's Hospital	tion, give street and nun	noer)		nardtown	or Death		St. Mary's	atti
Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs. last I	birthday) If Ur	nder 1 Year If Und	er 24Hrs. 8. Da	te of Birth(MM/DD/YYYY) 9. E	Birthplace (State or
Director		212-38-2952	1 M 2 X F	69	Yrs. Mon	nths Days Hours	s Min. 1.2	/28/1	940 Ma	eign Nand
	ŀ	Usual Residence of Decedent	1				1 12	/ 20/ 1	740 110	
v any		10a. State 10b. County 10c. Cify, Town or Location							10d. Inside City Limits	
Maryland 28a-f show d at once.	ō		lvert	H ⁻	untingtow					1 Yes 2 X No
Mary 28a-	Director	10e. Street and Number			10f. 2	Ip Code		10g.	Citizen of What Co	ountry?
th the 23a or	ä	3610 Huntin				20639			U.S.	
Baltimore, MD 21215-0036 germit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X				dent of Hispanic Ori cify Cuban, Mexican			14. Race - Ame White, etc.	erican Indian, Black,
er dez ', or i			1 Yes Divorced If Yes, Give Year	2 X No	1 Yes	2 X No specify:			Specify: W	nite
urs afi tural'	ğ	15. Decedent's Education (Sp	or Dates:			al Occupation (Give		e 16	Sb. Kind of Busines	
72 hor n "na al Ex	Completed	Elementary/Secondary (0-12	2) College (1-	4 or 5+)	during most of w	orking life. DO NOT	use retired)			
5-0036 led within 7 Hygiene. other than the Medica	립	12			homemak	ker			own he	ome
5-0 iled w Hygic d othe		17. Father's Name (First, Middle					r's Name (First, N			
2121 wild be fi Mental I marked c event,	Be	Thomas H	enry Weav		10h Mailing Addra	ss (Street and Nun	rances	Foy		A- 7:- C-4-\
ID 2 shoul and N 7 is m	욘	Thomas L. Mor				rkstone Dr				3104
and 2 and 2 fealth green 2;		20a, Method of Disposition			e of Disposition (N	ame of cemetery,	Date		Oc. Location - City	
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 X Burial 2 Cremati	_	III Otate	natory or other plac Memorial		12/07/2	010	D 1	MD
Itin		4 Donation 5 Other 21 Signature of Funeral Serving	Specify: de Licensee	30. 1		nd Address of Facility			Dunkirk,	
Inju	-	Sun.	1 Tula	110		lt. Harmon	Nauscii	Owin	ral Home	, P.A. 20736
Physician		23a. Part I. Enter the disease, failure. List only one caus	or complications that cause on each line	used the death. Do	not enter the mode	e of dying, such as c	ardiac or respira	tory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical	. 1	Immediate Cause (Final disease	B.A. Different and Co.	ries						Death
_xaiiiiiei	Н	or condition resulting in death)	Due to (or as a c	consequence of):						
	<u>ا</u>	Sequentially list conditions, if any leading to immediate	b Due to (or as a c	consequence of):						-
	Ę	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause								
ed isit	Xar	events resulting in death) Last Due to (or as a consequence of):								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Examiner	UNPENDED	dAMENDED							
'60, ate be ex ohysician he burial	edi	IF FEMALE:		utcome of pregnance	CV.			-	23d. Date of delive	200
1876 rtificat ing phy as the		23b. Was decedent pregnant in			₂ Fetal deat	h 3 Ectopio	c pregnancy		Month Month	Day Year
Box 68 c death certifi the attending ed for use as	sician	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 70 1 Yes 2 V No 9 Unknown 0 Unknow								
ords, P.O. Box 68' w requires that the death certifi s been signed by the attending should be detached for use as i	≥L	Part II. Other significant cond	9 Unknow		ting in the underlying	ng cause given in Pa	art 1 236	Did tobar	co use contribute t	o the cause of death?
P.O	þ	ratii. Other significant cond	ntions continuing to	Jean but not resun	ung in the briderlyii	ng cause given in Fa	1			obably 4 Unknown
Division of Vital Records, P.O tal or attending Physician: The law requires that it as firer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.							248	a. Was an		autopsy findings available
COF law re has bo	Completed	· · · · · · · · · · · · · · · · · · ·			<u> </u>			autopsy performe		completion of cause of
Reco: The law ficate has	Ö					00 Pl (P		Yes 2	No 1 🗸	Yes 2 No
ital sician s certi irecto	m	25. Was case referred to medic examiner?	All the state of t	patient 2 V ER	/Outpatient 3	26.Place of Death	Nursing Home		sidence 6 Oth	ar
n of Vital Recoing Physician: The law After this certificate has funeral director, page 2 st	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of	f Injury 28t	b. Time of Injury	28c. Injury at Work			injury occurred	91.
OD O	ഖ		nding Dec 3, 20)ay Year) 110 12	222 hrs	1 Yes 2 ✔	Driver		o collision	
ivisior or Attend after death Director:	lica		vestigation 28e. Place	of Injury - At home	, farm, street, factor	ry, office building, et				Rural Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director:	Ē	The street of Death Street of Death Street of Injury - At home, farm, street, factory, office building, etc. 1						nicsville, MD		
Hosp 24 ho Fune			Physician: To the best							
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Ex	xaminer: On the basis of and manner sta	examination and/o ated.	r investigation, in r	my opinion, death oc	curred at the time	e, date and	place, and due to	the cause(s)
	ž	29b. Signature and title of certif	fier	0	29	9c. License number		I _	d. Date signed (M	
		Mygnite	The free			O.C.M.E.			ecember 4, 20	010
1011) 10	ſ	30. Name and address of person		·		treet, Baltimore	MD 21201			
drw 10		Margarita Korell MD.		istrar's Signature	TITPEIIIS	treet, baitimore	s, IVID 2 120 1			
St Regist	ate	31. Date filed (Month, Day Year	6 2010 /2	Sulfat Signature	1. back	2				

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Records,

Division of Vital

Cornera

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 1- Registrar #23a & 26 per MD, RG FCHD 112 of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 2 Month Day **Physician** 2010 Year Robert Clinton MacMillan 03 6:30 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 Locust Blvd. Middletown Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Min. Davs Hours 213-22-4506 Director 85 10/14/1925 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location fshow 10a. State 10b. County 10d. Inside City Limits at MD Frederick Middletown ir than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Locust Blvd. 21769 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. TXT Yes 2 No 1943
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) teacher school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Robert MacMiller Ethel Allender ဥ 19a. Informant's Name/Relationship (Type. Print)
Leah MacMillan (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $11\ Locust\ Blvd.,\ Middletown,\ MD\ 21769$ Health sem 27 l permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XB rial 2 ☐ Cremation 3 ☐ Removal from State Reformed Cemetery 12/11/2010 Middletown, MD n 5 ☐ Other (Specify) 4 Donation ²Donald Address of Facility ompson Funeral Home POB 18, Middletown, MD 21769 e, or complication is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one callse on each line. . Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) CVA **Physician** CEREBRAL VASCULAR ACCIDENT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-trar and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 X Residence 6 □Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: 5 ☐ Pending investigation Hospital or Attending 1. Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) within 24 and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 36 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Odleton Mo

DHMH 17 Rev 1/2001

State

Registrar

HILLIA

Behre

31. Date filed (Month, Day, Year)

DEC

32. Registrar's Signature

Leveland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 6, 2010 10:45P M LORETTA Y. METZGER Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Kline Hospice House Mt. Airy If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea Oct. 3, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 192-05-9640 1916 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g Citizen of What Country Funeral 2100 Whittier Drive 21702 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: "natural" Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) <u>Wrapper/Warehouse</u> Department Store other traumatic event, Be .. Page 1 and 2 should be filed tment of Health and Mental Hi tant: If item 27 is marked otl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Yacavino Philomenia () Domenic Muccino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Twigger/Daughter 19332 Cissel Manor Drive, Poolesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department o Important: If any injury or once, ō 12/11/10 Calvary Cemetery Pittsburgh, PA 21. Signature of Funeral Service Licer se 22. Name and Address of Facility
Robert E. Dailey & Son Funeral Homes, P.A
1201 North Market Street, Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ardyo my of disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. E. its Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other (Specify) Hospital 2 No Other: ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident I Director: / Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Euneral D leted filled i Medical 29a. Certifier 📭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D60417 MD

Registrar

DHMH 17 Rev 7/2009

State

Hemen Sha

31. Date filed (Month, Day, Year,

Tohnson

DV

Darko

Frederick

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NEWLIN MILENA V. 618 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL Sothesda Mont gomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8 Date of Birth **Funeral** 1 M 2 F Months Days Hours Min. Month, Day, Year Director 577-46-6678 86 Republic Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4515 Willard Avenue 20815 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumoric once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jan Vanecek Alzbeta Otte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4515 Willard Ave., #S1710, Chevy Chase, Michael H. Newlin/Husband MD 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan
Crematory 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dec. 4,2010 Alexandria, Va. Signature of Oneral Service Lio 22. Name and Address of Facility DeVol Funeral Home M01315 2222 Wisconsin Ave., N.W. Washington, D.C.20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between A THLEROSCLEROTIC CARDIOVASCULAR DISEASE Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ANCREATIL CANCE Scuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PANCREATIC CANCEN 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an O performed Yes 2 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 0 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 60 injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation within 24 hours after der To the Funeral Director completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Z Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 62

State

8600 Old Georgetown Rd

ME

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

C

10037314

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 27, 2010 245 PMM Erma Α. Nadel Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 Months Days Hours Director 579-10-7196 92 08771274918 MaryTand Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City. Town or Location Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15101 Interlachen Drive #602 20906 United States or items permit. Page 1 and 2 should be filed within 72 hours after death in Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 Divorced Completed White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Resident Manager Property Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isadore Alper Rosa Rosenkoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5533 Marquesas Circle Sarasota FL 34233 Richard Levine - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. King David Mem Gardens 12/1/10 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) MO1163 Signature of Funeral Service Licenses fahransky coffdberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20582 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Onset and Death Physician/ Cardiac Arrest due to pneumothorax Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or iinjury that initiated events Sensis Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Year 1 Yes 2 No a 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha performed? Yes 2 No 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2**X** No Other: မှ 1
Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending s after death.

Director: Aff
d in by the fur 2 Accident
3 Suicide
4 Homicide 1 🗆 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 10 29c. License number 29d. Date signed (Month, Day, Yea

Registrar
DHMH 17 Rev 7/2009

State

Dhours

31. Date filed (Month, Day, Year)

Sumalatha Dhanireddy MD 18101 Prince Philip Drive Olney MD 20832

D70998

November 29, 2010

D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1/30/2010 Physician/ James William Oberholtzer 10:30 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbour Health & Rehabilition Cen. Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Hours Min. 1 3 M 2 1 F 11/27/1926 578-40-9009 Director 84 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director North Beach MD Calvert 1 🗌 Yes 2 🛚 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral P. O. Box 1352 20714 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 Never Married 2 X Married 1 X Yes Completed by 2 🗌 No 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Specify: White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Mechanic Telephone Company is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John W. Oberholtzer Grace Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Dorothy Terrill /wife O. Box 1352, North Beach, MD 20714 20a. Method of Disposition 20c. Location - City or Town, State N/A 20b. Place of Disposition (Name of Date N/A cemetery, crematory or other place/A 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature Funeral Service Licensee Goff 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami attending physician and for use as the burial-transit 4 4 Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performe certificate ha 2 **V** No Yes 2 NoNo 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural work? 5 Pending ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying flurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Cram Highway CW Clin LRW 20

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

32. Registra s Signature

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 25 2010 Calvin Parker Jr 1801 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months 1 ▼ M 2 □ F June Date Year 963 Maryland 47 Director 218-88-8416 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Direct Maryland Anne Arundel **Annapolis** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1100 Madison St. Apt B1 21403 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. Completed by 1X Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 XNo Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 10th 0 Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Calvin Parker Sr Mary Forrester and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Galloway (Mother) 1100 Madison St. Apt Bl Annapolis, Md.21403 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 12-3-10 Baltimore, Md. 21. Signature of Funeral Service Licenses Minimame Reduction Sons Mortuary, P.A. 821 West St. Annapolis, Md. se MO0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a c in equence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Pregnant at time of death sate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one D163/6 who completed cause of death (Item 23a) (Type Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Records,

Division of Vital

Registrar

31. Date filed (Month, Day, Year) 2010

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State

arke

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Charles Peters December 2:20 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9201 Glenville Road Montgomery Silver Spring Date o. (Month, Day, . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min 502-03-0022 Director 90 Feb Minnesota Usual Residence of Decedent shov 10a. State 10d. Inside City Limits 10c, City, Town or Location notified at Director 28a-f 1 X Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Examiner must be Funeral 23a 9201 Glenville Road 20901 United States items ; hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify "natural" 3 XWidowed 4 ☐ Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 Building <u>Contractor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any july or other traumatic once. Hermann A. Peters Sophie Bartak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Peters/son 5802 Wyndham Circle #105 Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 12/8/2010 | Woodbine, Maryland 21. Sign wre of Funeral Service ^{22 Name and Address of Eacility} Going Home Cremation Service P.O. Box 784 Thomas uanita Beverly L. Heckrotte, P.A. Clarksville, M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impuly that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Year Pregnant at time of death Unknown Month Day Yes 2 No 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? performed? certificate Yes 2x No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 \square Nursing Home 5 \bigstar Residence 6 \square Other (Specify) 1 🗌 Yes 2 X No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State Registrar 1355 Piccard Drive

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Year,

Coleman,

31. Date filed (Month

D37142

Rockville, Maryland 20850

December 6, 2010

State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dec 9, Physician/ .º2010 Plummer Lottie 12:05 AM Loretta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 12512 Bowling Street Allegany Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗆 F Months Days Min Oct 9 **Director** 217-10-5381 MD Usual Residence of Deceder 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a مr 24a-4 ما 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director Allegany MD Cumberland 1 ☐ **Xes** 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12512 Bowling Street 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 Midowed 4 Divorced Specify: white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Celanese Corp .aborer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or and Lottie Loretta (Riley) Fisher Richard Lenwood Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Fisher MD 21502 13107 Bowling Street nephew Cumberland Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 12/13/2010 St. Mary's Cemetery 4 Donation 5 Other (Specify) Cumberland MD 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funer VService Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ 1100 disease or condition 1 Medical resulting in death) Due to (or as a consequence of) Examiner Secure tially list no cold. s, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate 2 🛮 No Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide within 24 hours after death To the Funeral Director: filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature nd title of certific 29c. License number anery 30, Name and address of person who completed cause of depth (Item 23a) (Type, Print) KOBUSTIANO BARRERA 200 GLENN ST M.D 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician/ Dec 1Vera neid Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Mt. Airy 1001 Village Gate Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth
March 23,1924 Dominican Rebublic 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 🗆 M 2 🖾 F Months Days Hours Min. 76 **Director** 052-46-8443 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mt. Airv Maryland Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1001 Village Gate Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 within 72 hours after 1 X Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced Spanish 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home 6 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Fitem 27 is marked of ပ္ Fabio Pena Petronila Pena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other 1001 Village Gate Drive, Mt. Airy, Maryland 21771 Maria Rodriguez / Daughter 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory Inc. 12/8/10 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland. 21. Signature of Juneral Service Licer 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complication, the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final arci Physician/ noma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ng physician ar as the burial-ti Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown ó 9 Unknown s been signed by the should be detact Part II. Other Significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performe Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home Hospital: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 5X Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death.

Director: Aft
d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature d title of certiff 29d. Date signed (Month, Day, Year) 00004126 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 7401 Osler Drive, Towson, Maryland 21204

3. Time of Death

1 Yes 2 X No

Approximate Interval Between Onset and Death

8:00

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 30 2010 Linda Rogger-Rivera 2:30 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert 260 Dares Wharf Road Prince Frederick If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 □ F New York 083 40 3636 62 January 15 1948 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County r 28a-f shov notified at Prince Frederick 1 ☐Yes 2 No Directo Maryland Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ir than "natural", or items 23a or the Medical Examiner must be r 20678 United States 260 Dares Wharf Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examina-1 ∏Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🙀 No Baltimore, Maryland 21215-0036 Specify: white ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fashion Industry Buyer 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Giebler Robert Rogger 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guillermo Rivera - husband 260 Dares Wharf Rd. Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John Vianney Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Dec 4 2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Prince Frederick Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home PA Kausch 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malignant spinal ependymona **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Tes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 2 □ No 1☐ Yes 2 No 1 Yes the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 52 (Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA P 28b. Time of 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 173 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D17324 11/30/2010 Oc 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)
Raymon A. Noble, MD 238 Merimac Ct. Prince Frederick, MD 20678

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registra s Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DONNA Month Year A. RANDOLPH necember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death Shady Grove Adventist HOSPI tel Rocky. He Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🏻 F 79 Months June 27, 1931 Hours 483-30-2543 Iowa Director Usual Residence of Decedent 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 28a-f Maryland | Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ò 10f. Zip Code must be Funeral items 23a 16321 South Westland Drive 20877 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. "natural", or ģ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 X Widowed 4 Divorced is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Bureau of Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Investigation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Albaugh Gertrude Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Debra Konken (Niece) 2927 Logan Avenue Department of Health Important: If item 27 any injury or other to once. Waterloo, Iowa 20a. Method of Disposition 20b. Place of Disposition (Name of December 6 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Pk. 2010 21. Signature of Funeral Service Litensee 22. Name and Address of Facility DeVol Funeral Home MolliG 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Cardio Pulmonar Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** olonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir bunial-trade breas+ that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the a d be detached f 9 Unknoy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending 1 Tyes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0661512

State

Registrar

10

990, medical Car Dr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

Bangalore

06

MADAN 31. Date filed (Month, Day, Year) december 1, 2010

Rockville MD 20150

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 10:03 PM December Anita Rush Jean Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 5, 1929 9. Birthplace (State or Foreign Country) New Jersey Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Hours Director 150-22-6270 81 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland 1 Yes 2 X No Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 857 Diamond Drive 20878 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X** No "natural", or Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: African—American 3
Widowed 4
Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file.
Department of Health and Mental IImportant: If item 27 is marked of
any injury or other traumatic even
once. ပ James Patterson Ruby Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley R. Bonney/daughter 857 Diamond Drive Gaithersburg, Maryland 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/8/2010 Woodbine, Maryland 21. Sign Rure of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Muanita thomas M00957 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death vascular accident Immediate Cause (Final disease or condition cerebral Physician/ Medical resulting in death) Due to (or as a consequence of): piration **Examiner** pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitus chronic Kidney 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 0 bstructive pulmonan 24a. Was an autopsy performed' 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signayu e and title o 00069336

State Registrar Janelle

31. Date filed (Month, Day, Year)

DEC 07

M

December

L

32. Registrar's Signature

Williams, MD 9001 Medial Center Drive, Rockville, Mary 15rd 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Physician/ Year KEMME 12 P AN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AIRHAVE Sykesville Carroll 7. Age (In vrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days May 7, 1921 1 ∕ M 2 □ F Hours Min. **Director** 214-18-568 89 Yrs Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland Carroll Sykesville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 7200 Third Avenue 0-107 21784 United States 72 hours after death 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Fant: If item 27 is marked other than jury or other traumatic event, the In yor other traumatic event, the In Owner/Operator Tape & Label Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Remmel Frances Spear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Remmel/wife 7200 Third Avenue 0-107 Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If ite cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/7/2010 Woodbine, Maryland Signat ve of Funeral Service Licens Going Home Cremation Service P.O. Box 784 anita M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last signed by the attending physician and deelached for use as the burlal-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò renal 2. No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? After this certificate 2 N 1 🗌 Yes 2 🗀 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After thileted filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work 1 \square Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check within 2. Captifying Norse Prentioner: To the best of my knowledge, death occurs 29b. Signature and title of certifie 34849

State Registrar 31. Date filed (Month

645

32, egistrar's Signature

be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1an MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 8 per DVR G910 12/22/10 dk

State of Maryland / Department of Health and Mental Hygiene 2 1 | 1 For State Registrar Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RIFFEY Month VELMA 2010 Medical 4a. Facility Name (if not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 18 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1<u>925</u> Hours 1 M 2 AF 225-32-2846 85 Director Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a ~ ~ ~ one any injury or other traumatic event, the Maryland once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMONE DUNDALK 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 54. Helens 21222 215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 2 No 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 🗷 Widowed 4 🗌 Divorced Specify: Wh. E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GARMENT MP6 ENMSTRE 55 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည RUTH CONIEL UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Adams (Dau) Broening MID 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Sulphen SARMGGM 12/13/2010 Chilhowne, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signala e Fun Pervice Licensee 22. Name and Address of Facility 938 N. KLAIN MAKION UA 24354 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

24 Rows Immediate Cause (Final Physician/ RESPIRATORY PAILURE disease or condition Medical resulting in death) Examiner PNEUMONIA Sequentially list conditions, Examine Due to (area e consequence of) cause. Enter Underlying Cause (Disease or linjury the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.Ö. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No this certificate has been signed by the atteral director, page 2 should be detached for Dav Year Pregnant at time of death 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The I
 24 hours after death.
 Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No ၉ 1 🗌 Yes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury 1 X Natural ☐ Accident 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. only one) 29b. Signature an 29c. License number RES-000 DEC 7,2010 MD ress of person who completed cause of death (Item 23a) (Type, Print) 1/4940 EASTERN AVENUE BALTIMORE, MD, 21224 MD ADEL EL BOUEIZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Kasan Registrar

State of Maryland / Department of Health and Mental Hygiene 2 U | U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ -DWIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea Oct. 9 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 DM 2 □ F Days Hours 95 Yrs. **Director** 094-05-6392 New York Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔽 No Anne Arundel Gambrills MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21054 USA 2605 Chapel Lake Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11. Marital Status Armed Forces?
1

Yes 2
No
If Yes, Give

No Black, White, etc. and Mental Hygiene. is marked other than "natural", or i þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: WW II 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) School Maintenance Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil tment of Health and Mental rant: If item 27 is marked o ၉ George W. Smith Edna Morse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 332 Stonehouse Drive Severna Park, MD 21146 Patricia P. Lehmann/POA Department of Health Important: If item 27 any injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 2010 Baltimore, MD 4 Dopation 5 Other (Specify) 22. Name and Address of Facility Barranco & Sons 495 Ritchie Hwy Signature of Funeral Service Ligenses P.A. Severna Park Funeral Home Severna Park, MD 21146 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Beath Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin that the death certificate be executed the burial-transil Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year signed by the aid be detached to 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? 2 🗆 No 1 Yes Yes 2. Hospital or Attending Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner? Other: 2 No ပ္ T☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of who completed cause of death (Item 23a) (Type, Print) lame and address of person ANNAPOLIS MOLIYO A EN 441 w Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Velma Smith 2010 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12401 Lime Kiln Road Fulton Howard Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours May 8, 1921 426-28-4918 1 □ M 2 🛛 F 89 MS **Director** Usual Residence of Decedent 10b. County e filed within 72 hours after death with the Maryland tal Hygiene.

and of other than "natural", or items 23a or 28a-f showed other than "natural", or items be notified at event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits rector MD Fulton Howard 1 Yes 2 X No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20759 12386 Kondrup Drive USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked cany injury or other traumatic eve ည John Orsey Porter, Sr. Velma Anne Hutson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon N. Prada/Daughter 12390 Kondrup Drive Fulton, MD 20759 Baltimore, 20b. Place of Disposition (Name of Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
Arlington National 1 Burial 2 Cremation 3 Removal from State January 2011 12 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Rarranco & Sons, 495 Ritchie Hwy. Funeral Home Severna Park na Park, MD P.A. Se Severna Part 1. Enfecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final ESPIRATORY Ph sician/ disease or condition Medical resulting in death) as a consequence of) Examiner Neimania Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events everitare ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ mas lledus 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 🗌 Yes completed filled in by the funeral director. 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 2X No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 1 Yes Group Hand 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/2 Natural 5 Pending 1 \square Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1-4 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination arror investigation, in my opinion, south a state and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 2856 Colembia, me 20049 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month

Registrar

DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

1355 Piccard Drive, Suite 100, Rockville, Md. 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signature

Geoffrey Coleman, M.D.

DEC

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink Ensura All Copies Are Legible.

Amend Item 30 per DVR G910 12/2 Ensura All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 03 Day 201 O Par Physician/ 1 Month Harold Rusher Schilling 10:30P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Kline Hospice House Mt. Airy 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🛣 M 2 🗆 F Days 90 Months Hours Min. (Month, Day, Year) IN (1) 311-03-8266 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director MD Frederick Frederick 1 ☐ Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 7407 Willow Rd. 21702 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian, Armed Forces? 1944 1 Yes 2 □ No Black, White, etc. δ. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 1946 Specify: White 3XXWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) store manager retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jacob Howard Schilling Nova Rusher 19a. Informant's Name/Relationship (Type, Print)
Lou Ann Lushbaugh (Daughter) 8842 Indian Springs Rd., Frederick, MD 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 Department of Health Important: If item 2: 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Byriai 2 ☐ Cremation 3 ☐ Removal from State Reformed Cemetery 12/7/2010 Middletown, ation 5 Other (Se Sign ture ²Donal Address of Facility ompson Funeral Home POB 18 Middletown. MDenter the dise molications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List d ly one cause on each line. Interval Between Onset and Death Imm iate Cause (Final diseas condition Physician, PAI Medical resulting in death) Due to lat as a or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans Cause (Disease or it that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year g Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to, 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2X No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 2 🗆 No 1 Tes Was case referred to medica filled in by the funeral director, wfold 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: ည 1 Tyes 4 Nursing Home 5 Pesidence Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check 2 Medical Examiner: On the basis of examination and/or investig 3 Certifying Nurse Practioner: 16 the best of my knowledge, de within 2 ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of dertifier 29d. Date signed (Month, Dav. Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 West Ninth Street, Frederick MD 21701 Dr. Casper Cline, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 2105 M LIZ abeth 12 DIO Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Haberstown tealth (Washington JuliaManor Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov • 2 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F Davs Hours Mary Land **Director** 89 215-18-2458 Nov. Usual Residence of Decedent f show 10a. State 10b. County : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21742 <u>13610 Grandview Drive</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify. 3 X Widowed 4 ☐ Divorced Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Nurse's Aid Home Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Fout Alcie Mays 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 950 Cypress Street, Chambersburg, Pa. 17201 David Sharer - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Hill Cemetery 12/7/10 Hagerstown, Maryland Signature of Funeral Service Licensee Minnich Funeral Home 22. Name and Address of Facility E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) erebral Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Dertension that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Renal Insuff iciency 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Voscular Dementia, Major Depression 24a. Was an autopsy After this certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be (26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?

1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Prophosis Naclaw-Blucker, CRNP 333 N. 1115 treet, Hagerstown, MD 21740 Borbara Naden-Blucher, CRNP

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 December Alma Louise Smith 11:40aM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 46 Farrow Lane Ceci1 North East Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Jan 21, 1 🗆 M 2 🗶 F Months Days Hours 218-16-2414 Director 86 Yrs. MD Usual Residence of Decedent permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD North East 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 46 Farrow Lane 21901 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 XMarried δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: White Completed 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Thomas Alma Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren Smith / Husband Farrow Lane North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/7^D 2010 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Nottingham Cemetery Colora, MD Name and Address of Facility .T. Foard Funeral Home, P.A ll S. Queen St. Rising Sun, 21. Signature of Funeral Service Licensee P.A. schar Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stionly one call se on each line. Approximate Interval Between shock, or heart failure. List only one call Immediate Cause (Final Onset and Death #Hysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: ဂ္ 1 Tes this 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) 2

Registrar DHMH 17 Rev 7/2009

State

30. Name and a

31. Date filed (Month, Day, Year)

USING

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	For State Registrar	110			nd / Depa	artment	of Health and of Death			0010	40190
Physician/ Medical Examiner	4a. Facility Nam	e (if not institution	Anne R. T	mber)			wn, or Location of Dea	2. Date of December	Day 1 4c.	2010 County of Death	3. Time of Death 5:40 AM
Funeral Director	Montgon 5. Social Securit 178-1 Usual Residence	y Number 4-6734	neral Hosy 6. Sex 1 \(\text{M 2 \(\text{Z} \) F	7. Age (In yrs.		If Under 1	Year If Under 24 Hr Days Hours Min			Montgomer g. Birthe Peny	y place (State or Foreign try) us ylvania
a or 28a-f show be notified at al Director	10a. State Marylay 10e. Street and	10b. County	ntgomery	10c. Ci	ty, Town or Loo	10f. Zip C	Silver S	Spring	10g. Cit	izen of What Coun	0d. Inside City Limits 1 ☐ Yes 2 🗓 No
al", or items 23a c Examiner must be	11. Marital Statu		Armed F	edent Ever in U. orces? 2 X No ive	S. 13. V		t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or N rto Rican, etc.)		14. Race - Americ Black, White, e	
ygiene. her than "natural" it, the Medical Exa e Completed	Elementary/S	Specify only high Seconday (0-12)	ent's Education est grade completed College ((Give F life. D	O NOT use re	done during most of westired) Manager			ind of Business Ind	dustry
7 is marked othe raumatic event,	19a. Informant's	Name/Relations	ick Lewis hip (Type, Print)		19b. Mailin		street and Number or F	Rural Route Num	ither ber, City or	ine Bish Town, State, Zip C	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of I 1 Buriel 4 Fonat	Disposition		20b. l	Place of Dispo cemetery, cren LTUMOTO LOUGO 22	sition <i>(Nam</i> e natory or oth 2. Chem 3. Name and a	er place) atory 2 12/0 Address of Facility H	Date 06/2010 ines-Ri	20c. Lo Bal raldi	ocation - City or To Ctimore, Funeral	Maryland Home, Inc.
burial transit burial transit burial transit cal Examiner	23a. Part 1. Ent shock, or I Immediate Cau disease or conductive conductions of the Sequentially list if any, leading to cause. Enter UI Cause (Disease that initiated ever resulting in dea	neart fail use List se (Final lition th) conditions, b immediate iderlying or linjury ents	a. Due to	ach line.	fronto. uence of): d uence of):	er the mode o	of dying, such as cardia	ac or respiratory		or sproce	g, MD 20904 Approximate Interval Between Onset and Death
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of								-	23d. Date of delive Month	ery Day Year
been signed by should be deta leted by PI	Part II. Other sig	gnificant conditi	ons contributing to	death but not re	sulting in the u	nderlying cau	use given in Part I.		Yes 2		e cause of death? pably 4 Unknown psy findings available
ertificate has been signator, page 2 should the Completed	25. Was case reexaminer?					_	26. Place of Death (Ch	au pe 1 🗀 Ye	topsy rformed? s 2 No	prior to cor death?	mpletion of cause of
after death. Director: After this con in by the funeral dire Certificate: To	1 Yes 27. Manner of D 1 Natural	examiner? 1								Other (Specify)	
in 24 hours after the Funeral Direction by pleted filled in by Medical Cert	4 Homici	1 Certifyin	Physician: To the		y) /ledge, death c	occured at the	e time, date and place,	City or 1	cause(s) an	d manner as state	
To the comple		nd title of certifie	M 9inl	h		29c. L	d at the time, date and pricense number	place, and due to	29d. Dat	and manner as state signed (Month, L	
State Registrar	30. Name and a Dichthuo 31. Date filed (M	ng M.	who completed cau	ISIOI Registrar's Signa	Prince	Philip	prive, C	Iney,	MP	20832	

			For State Registrar	State of Ma	arylan		artment o			-	giene Reg. No	010	40191
	Physici	an	1. Decedent's Name (First, Middle, La	A						2. Date of Dea	Day	Year	3. Time of Death 8:00A M
	/Medic		4a. Facility Name (If not institution, give	The mpser		-	4b. City, Towr	or Location	of Death	vec	40.0	2010 County of Dea	
	Examin	ıer	2 1	Rua L				Serch	TOI Death			top fei	· .
	Funeral		5. Social Security Number 6. S		e (In yrs. i	last birthday)	If Under 1 Ye	ar If Unde	r 24 Hrs.	8. Date of Bir (Month, Da		-	rthplace (State or Foreign ountry)
	Director		164-28-6811	X M 2□F	75	Yrs.	Months Da	ys Hours		10/31/			ennsylvania
	P .		Usual Residence of Decedent		10 00								10d. Inside City Limits
	arylar show	'n	10a. State 10b. County	- 3	10c. City	y, Town or Lo	cation teford						1 □Yes 2X No
	he M	ectc	MD Harfor	a		MIIT					10a Citiz	en of What C	
	with t	ij	10e. Street and Number 1732 Ridge Roa	nd			10f. Zip Cod	ັ2116	0			USA	ountry;
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "natural".	Funeral Director	11. Marital Status	12. Was Decedent I	ver in U.	S. 13.	Was Decedent	of Hispanic O	rigin? (Sp	ecify Yes or No			erican Indian,
0	fter d riten	F	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☐ ✔			Was Decedent If Yes, specify C			Rican, etc.)		Black, Whi	te, etc.
0000	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2∏X	No Specify	y:			Specify:	White
- -	72 ho natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usual Oc	cupation ne durina mo	st of work	ina	16b. Kin	d of Business	s/Industry
7	ithin ne.	lg m	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work do DO NOT use re	tired)			M		turing
V	led w Hygie her tl		10			We	lder	10 Moth	hor's Norm	e (First, Middle,			turing
		Be	17. Father's Name (First, Middle, Last							Sing]			
Š	should be ind Mental i marked c imatic ev	은	Arthur Thomps 19a, Informant's Name/Relationship			10b Mailie	ng Address (Str	1					Zin Code)
2	d2s Ithan 17isi traun		Esther Thompso			1	2 Ridg						21160
ນົ	Hea F Hea tem 2		20a. Method of Disposition)11, WIIC	20b. P		esition (Name or matory or other			Date			r Town, State
2	ages ent of tt: If i		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	- I		natory or otner idge C		12/1	4/201) De	lta.	PA
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of August Prail Service Le	The state of the s	1010		2. Name and Ad			-,			
Ď	a mp per		C Koley for	Jusan		H	arkins	Fune	ral	Home,	Inc	., De	lta, PA
	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final		ne.		ter the mode of			or respiratory a	arrest,		Approximate Interval Between Onset and Death
2	/Medical		disease or condition resulting in death)	Due to (or as			1-20-						70.00
	Examiner		Convention list conditions	h 1750	O								Years
	D .tz	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):							1
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as		uonas af\;							Yeani
0/00	cate be executed physician and the burial-transit			Due to (or as	a consequ	derice oi).							
00	ficate phys s the	dical		_d									
YOU	certii nding Ise a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							2	3d. Date of d	elivery
ă	death e atte d for u	iciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			☐ Ectopic pregr ☐ Other <i>(specif</i>)					Month	Day Year
5	t the o	hys	9 Unknown	9 🗌 Unknown									
'n	s that gned l e det	by P	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the u	nderlying cause	given in Part	t I.	23e. Did	tobacco us	se contribute	to the cause of death?
cords,	equire en siç ould b	ed k	Parlamsons		q	nemia				1 🛂	Yes 2]No 3□I	Probably 4 ☐ Unknown
ב ב	law re as be 2 sho	Completed	Mzcheimers							24a. Was auto		24b. Were a	autopsy findings available o completion of cause of
ב	The ate h	E O	COPD							perfo	ormed?	death?	
VILAI	sician: The law certificate has b irector, page 2 sl	Be C	25. Was case referred to medical examiner?							h (Check only			
5	hysic his co		1 Yes 2 No				nt 3 ☐ DOA	Other: 4 🗆 i	Nursing Ho	ome 5 Res	idence 6	Other (Sp	pecify)
=	ing P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y, Year)	28b. Time o Injury		njury at Vork?		28d. Describe	how injury	occurred /	
VISIOII	tend leath. tor: / the fi	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		411			1 □ Yes 2 [_INo	00/ 1	(0)		5 15 1 N 1 h
=	or At offer of Direct in by	ŧ	4 ☐ Homicide determined		ury - At no c. <i>(Specif</i>	ome, tarm, sti fy)	reet, factory, on	ce		City or To	wn, State)	a Number or I	Rural Route Number,
	pital ours a eral C	ပ္သ	29a. Certifier 1 ☐ Certifying P	hysician: To the best	of my kno	wledge deal	th occurred at the	ne time, date	and place	and due to the	called(e)	and manner	as stated
	Phos 24 hc Fun etely	edical		miner: On the basis o	f examina								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burus after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	29b. Signature and title of certifier				29c. Lic	ense number	r		29d. Date	e signed (Mo	nth, Day, Year)
			1 Wand K	lu mo			702	1295			12/10	110	
			30. Name and address of person who	completed cause of d	eath (Iten	n 23a) (Type,		p po (4					
			Words Klorsz	mo 57	0;	kenw	ical Au	13	alle	mue >	no s	120%	
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ature							

かん

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	e Type or Pr						_		_	
		For State		State of N	/larylar		artment of I tificate of I			/lental Hy	gien	5010	40192
		Registrar 1. Decedent's Name	e (First Middle I	ast)		Cer	lilicate of t	Jeani		2. Date of De	Reg. N	0.	3. Time of Death
Physicia		GEORGE			SEN					DECEMB:		3 2010	3:45 P M
Medic Examin			-	ive street and number)			4b. City, Town, o	r Location	of Death	2202		c. County of Deat	
		FREDER	ICK M	EMORIAL I	HOSPI	ITAL FREDERICK						FREDERI	CK
Funeral		5. Social Security N		. Sex 7. A 1 X M 2 □ F		yrs. last birthday) Nonths Days Hours Min. Noct.					th y, Ye <i>ar</i>)	9. Bir Co	thplace (State or Foreign untry) MD
Director	3	213-16-06 Usual Residence of			89) 115.		<u></u>		Oct. 18	5, <u>1</u>	921	MD
shov dat	tor	10a. State	10b. County		10c. Cit	10c. City, Town or Location							10d. Inside City Limits
Mary 28a-1 otifie	irec	MD	Frede	rick	Fred	Frederick							1¾☐ Yes 2 ☐ No
th the 3a or t be r	Funeral Director	10e. Street and Nun				10f. Zip Code 21702					10g. C	citizen of What Co A	ountry?
ath wi	nne	2100 B. 1	Whittle	12. Was Decedent	Ever in U.	S. 13 V	Vas Decedent of H	lispanic O	rigin? (Spe	ecify Yes or No-		14. Race - Ame	rican Indian
er de	by F	1 Never Marr	ied 2 Marrie	A F	?		f Yes, specify Cuba	an, Mexica	an, Puerto			Black, White	
urs aff ural", al Exa		3 🗌 Widowed	4 Divorced	If Yes, Give Year or Dates.	WWII	1	☐ Yes 2 No	Specify	y:			Specify: Wh	ite
72 hor "mat ledica	Completed	(Spe	15. Decedent's acify only highest	s Education grade completed)		(Give	lent's Usual Occup kind of work done	during mo	st of work	ing	16b. l	Kind of Business	Industry
rithin lene.	Con	Elementary/Second 1.2	onday (0-12)	College (1-4 or	5+)	1	O NOT use retired) etary/Tr		ror			Furnitu	re Store
iled w of Hyg of he	Be	17. Father's Name (First, Middle, Las	st)		1 Sect	erary/II			e (First, Middle,	Maider		ite btore
d be f Menta arked atic e	욘	Eldred W	. Van F	ossen				Eliz	abet	h Remle	v		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na				19b. Mailir	g Address (Street	and Numb	ber or Rura	al Route Numbe	r, City o	or Town, State, Zij	Code)
and 2 Health em 27 ther to		Linda C1		-daughter	Loo.		Glen Hea	ather:					
ige 1 and of H		1 🖾 Burial 2	☐ Cremation 3	☐ Removal from State	e C	cemetery, cren	sition (Name of natory or other plac			Date		_ocation - City or	
artme ortan injuny		4 ☐ Donation 21. Signature of Fu	5 Other (Speneral Service Lice		Res		Mem. Gar Name and Addre		12/9			ederick,	
permit Depar Impor any in			09.1	MI	_		621 Opos						-
THE RE		23a. Part 1. Enter t	the disease, or co	omplications that cause y one cause on each li	ed the deat								Approximate Interval Between
Physician/		Immediate Cause (disease or conditio	Final			0657	netive	20 le	non.	ere a	lise	ease	Onset and Death
Medical Examiner		resulting in death)	4	Due to (or as	s a conseq	uence of):		1		J			7.3
-Administra	er	Sequentially list co	nditions,	b. — Due to (or as	2 2 22222	uongo ofi:						_	
ed	Examiner	if any, leading to in cause. Enter Under Cause (Disease or	rtyling T	Due to (or as	s a consequ	derice oi).							
executed ian and urial-transit	Exa	that initiated events resulting in death) I		C. Due to (or as	s a conseq	uence of):			_				
te be e	Jical			d									
rtifical ing ph e as th	Physician/Medic	IF FEMALE:		20 1/							Т		•
ath ce attend for us	cian,	23b. Was decedent in the past 12	months?	23c. If yes, outcom 1 Live Birth 4 Pregnant	2 Feta	al death 3	Ectopic pregnand Other (specify)	су			- 1	23d. Date of de Month	livery Day Year
ne dea / the a	ysic	1 Yes 2 L 9 Unknown	□ No	9 Unknown		death 5 L	Other (specify) _						
that the				contributing to death							obacco	use contribute to	the cause of death?
uires in sign	Completed by	CAD,	a fil	crie-Too	ensi	m	aorhic	ster	2012	1 🗆	Yes 2	2 □ No 3 □ P	robably 4 Unknown
iw req	plet	Charc	or - ma	crie-Too	19	BPH	1. dià	6et	es	24a. Was		24b. Were au	topsy findings available completion of cause of
The la ate ha	Com										rmed?	death?	s 2 N o
cian: sertific setor,	Be	25. Was case referre examiner?		Hospital:				lace of De	ath (Checi	(only one)			
Physical this call direct	2 1	1 Yes 2 2 27. Manner of Death		1 Inpa		ER/Outpatier 28b. Time of	t 3 DOA Oth	<u>4 ∐ N</u>				6 Other (Spec	ify)
ding th. After fune	cate	1 ☑ Natural 2 ☐ Accident	5 Pending	(Month, D		injury	work		_	28d. Describe I	iow iriju	ry occurred	
Atten ector by th	Certificate:	3 Suicide	6 Could no	t be 28e. Place of Ir			eet, factory, office	_					ral Route Number,
tal or rs a tal al Dir	S C			building, e	tc. (Specify	<i>''</i>				City or Tov	vn, State	9)	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours are death. To the Funeral Director. After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	edical	(Check 2	Medical Exa		examinatio	n and/or invest	igation, in my opinio	on, death o	occurred at	the time, date a	and plac	e, and due to the	cause(s) and manner stated
o the inthin 2 or the lomple	Me		Certifying N	urse Practioner: To th				e time, dat			e cause		stated.
F ≥ F Z		() ()	mol	ION	MD		Ø Z		36		12	5	10
		30. Name and addre	ess of person wh	o completed cause of	death (Item	n 23a) (Type, F					,	/ /	-
OHUA		A. WON	ELSON	1, MD 65	C 7	Homa.	S UDHAL	SON	se.	fre	DER	UCK, M	1 21702
Stat	e	31. Date filed (Monti	h, Day Year)	7 20 (32. Regist	ar's Signa	ture	Jarke						
Registra	ir		270		EN JELLES ENERGY	ja.	MA GRANIE				·· <u> </u>		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20 ใช้ December 9:30 рм Alison Louise Viewig /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Lorien | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12/02/1936 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 1 M 2 X 74 214-34-4629 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TANO Director Ellicott City MD Howard 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? United States 21043 4475 Montgomery Road A-113 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Credit Union Switchboard Operator 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Prott Helen King ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gaye Nickle - daughter 5330 Briar Oak Court Ellicott City, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/08/2010 Dulaney Valley Timonium, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Inter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unknow Ecquentially list or offices, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ∐Yes 2 KNo 9 ☐ Unknown in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an diseas 25. Was c referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Z ☐ Accident

and burial-trar Box 68760, physician certificate be as attending asn ō P.0. Division of Vital Records, has page 2: certificate Hospital or Attending Physician; After

death.

To the

Funeral

Director

28a-f show

r than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at

"natural", or

12 should be filed w h and Mental Hygiei ' is marked other th

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev

Physician /Medical Examiner

3altimore, Maryland 21215-0036

124 hours after death.

In Funeral Director: A pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in by the funeral pletely filled in pletely

Certification:

Medical

5 Pending investigation

6 ☐ Could not be

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

ano

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#26 per NP State of Marylan Registraf 2/3/2010 AACO HEALTH DEPT. OM Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ILSON 2100 UNNE 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 1136 Pewter Ct. Bowie If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) 12/21/1953 1 M 2 D Director 205-44-0673 56 Pennsvlvania Jsual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD 1X Yes 2 ☐ No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1136 Pewter Ct. 20716 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 0 1 Never Married 2 X Married Black, White, etc. Completed by Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene. is marked other than "natural", If Yes, Give Specify Black 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Management Analyst Food and Drug Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important; If item 27 is marked of any injury or other traumatic eve ဂ Lawrence U. Caution Margaret Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Wilson /spouse 1136 Pewter Ct., Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State cemetery, crematory or other place Metro Crematory 11/27/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. f. 1. Enter the liseas shock, or heart failure. or, or com, cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only the cause on each line. Approximate Interval Between Immediate Cause (Final Onset and D th Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Gequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Dav Year signed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed' Yes 2 1 🗌 Yes **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 X Residence 6 Techner (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation completed filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of seath (Item 23a) (Type Print) 445 DEFENSE HWY, ANDAPOLIS, MD. 21401

State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mildred E. Wilson December 2010 :45a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1004 Crown Street Carrol1 Mt. Airy Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Yea ec. 21, Months Days Hours Min. 1 □ M 2 🖾 F Yrs Director 70 214-36-0369 Marvland Usual Residence of Decedent show ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1004 CRown Street 21771 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏲 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Electronic Technician Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence Mallott Gladys Harbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Daniel D. Wilson / Husband 1004 Crown Street, Mt. Airy, Maryland 21771 Department of Health Important: If item 2 any injury or other t other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Prospect Cemetery 12/8/2010 Mt. Airy, Maryland Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Stage IV Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🖾 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed this certificate 1 Yes 2 No Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) Hospital 잍 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 00059924 12/6/10

State Registrar address of person who

31. Date filed (Month, Day, Year)

Acon, MD

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital

Wedical

MYVIEW

32. Register's Signature

1502 5 Main St +202, Mt Arry MD 2177(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Of IVIA	•	•	f Health and I	vieritai mygi	ierie	
			Registrar		Certificate	of Death		g. Ne.)	10196
	Physicia	'n	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Dav Year	3. Time of Death
	/Medic		Joyce Helen Wagner				Decemb	2r 2,2010	11:50 AM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Tow	n, or Location of Death	1	4c. County of Dea	th
			Ravenwood Lutheran Vi	llage	Hazer	Stown		Washing	iton
	Funeral		5. Social Security Number 6. Sex 7. Age 1 ☐ M 2 🕅 F	(In ya. last birtl	Months D	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign ountry)
	Director		220-26-5247	79	rs.	, I	Nov. 29	1931 Pen	nsylvania
7	2		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town	or Location				10d, Inside City Limits
chic	sho	_	Toa. State Tob. County	Toc. City, Town	Or Education				1 ☐ Yes 2 🌠 No
A 00	8a-f	Director	Maryland Washington	Ha	agerstown				
ŧ	or 2	Ë	10e. Street and Number		10f. Zip Co	de	10	ng. Citizen of What Co	ountry?
4	\$ 238	Funeral	1180 Tranquility Drive			742		USA	
r o	tems	nu	11. Marital Status 12. Was Decedent E Armed Forces?		13. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
D to	ori in	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 N If Yes, Give 14 Give 15 Give 16 Give 17	0	1 □ Yes 2 🔀	No Specify:		Specify:	White
3	uraľ,	8		100	 		T.	10h Kind of Duning	
5 8	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual O (Give kind of work d	ocupation one during most of wor etired)	king	16b. Kind of Business	rindustry
1	than	티	Elementary/Secondary (0-12) College (1-4or 5-	-)				Retail Sa	100
IIIU Z I Z-73-0030 he filed within 79 hours after death with the Mandard	ther it,		12 0	Ket	ail Manag	• • • • • • • • • • • • • • • • • • • •	ne (First, Middle, N		ites
ם ק	ed o	Be						iaicon carraino)	
X	and Mental Hygiene. Is marked other than aumatic event, Ite M.	မ	George Powe11 19a. Informant's Name/Relationship (Type. Print)	105	Mailing Address (C)	Helen S	touffer	City or Town State	Zin Coda)
ב א	traul		, ,		•		·		. ,
e, mai yid	The faith and Mental Hygiene. The faith and Mental Hygiene. The faith and Mental Hygiene. Other traumatic event, the Modical Experiment rest be rediffed at		Donna Wagner - Daughter 20a. Method of Disposition			Drive, Bo		Mary Land 20c. Location - City or	
5	9. 14 of 0.		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State		Disposition (Name of crematory or other	i		,	
3 3	rtmer		4 ☐ Donation 5 ☐ Other (Specify)	Rose I	Hill Ceme		·		, Maryland
ָם פֿ	perfile. Tages Failed. Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	1				uneral Hom	
	10 = 0 0		ook Hann	e)		Vilson Blvd			
			2.3 Part 1. Effer the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do n e.	ot enter the mode o	dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	hysician	- 1	Immediate Cause (Final disease or condition	Chouse	us a	escare			34 Lows
	/Medical		resulting in death) Due to (or as	consequence o					t
=	xaminer		Sequentially list conditions, b.						
D	# #	<u>e</u>	if any leading to immediate Due to (or as a	consequence of	f):				
ecute	trans	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a						
oor oo, ifficate be executed	physician and s the burial-transit	Ω	Due to (or as a	consequence o	т):				
2 de 0	ohysi the b	edical	d			·			
	5 0 6		IF FEMALE:					1/4	
ה ק ה	ttend or us	an	23b. Was decedent pregnant in the past 12 months?	2 🗀 Fetal death	3 ☐ Ectopic preg			23d. Date of de Month	elivery Day Year
, e de	the a	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other (special	y)		Monar	bay Tour
i ter	detached	F.		4 4 i	ale e con d'e de de e	i i- Dort I	220 Did tob	saca usa cantributa t	to the cause of death?
ē, ģ	signe be d	ρ	Part II. Other significant conditions contributing to death bu	t not resulting in	the underlying caus	given in Part I.			
	s peen s	ted					1 □ Ye	s 2 No 3 F	Probably 4/2 Unknown
ֻ פַּ	has b	싎					24a. Was at autops	24b. Were a	utopsy findings available completion of cause of
	ate h	Completed					perforn	negl? death?	s 2□No
<u> </u>	his certificate ha	Be (25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one		
A I	dire	2		nt 2 🗆 ER/Out	patient 3 DOA	Other: 4 \sum Nursing H	ome 5 Reside	nce 6 NOther (Sp.	ecity) consisted ling
- 2	h. After thi funeral		27. Manner of Death 1 ✓ Natural 5 ☐ Pending (Month, Day	y 28b. Ti (<i>Year</i>) In	ime of 28c.	Injury at Work?	28d. Describe ho	w injury occurred	
	ath. he fu	㇠	2 ☐ Accident investigation		М	1 ☐ Yes 2 ☐ No	Target I arrive		
Y Att	recto	≝	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju	ry - At home, far . <i>(Specify)</i>	m, street, factory, of	ice	28f. Location (St. City or Town	reet and Number or F	Rural Route Number,
Hosoital or Attending Physician: The law requires that the death cer	al Di	Certification:						•	
030	uner uner		29a. Certifier (Check only) Certifying Physician: To the best of	f my knowledge,	, death occurred at t	ne time, date and place	e, and due to the carried at the time de	ause(s) and manner a	as stated.
H ed	within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	one) and manner sta						
101	Tol	Σ	29b. Signature and title of certifier	00 A		cense number		9d. Date signed (Mon	
	NF		Manifer Jan		(228365		12-3-1	
	3		30. Name and address of person who completed cause of de	11	Type, Print)	. 1	0 1	4.0	
			MAN LALL OSHAFI	368	nell	21- Na	Brew	MDZ	1740
	Stat	te	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	1.41		_		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Francis Wittkamp Mq Bernard Nov. 30. 2010 8:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Hill Assisted Living Dayton Howard Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year 1 XM 2 🗆 225-12-5709 Director 89 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland at Hygiene. 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6326 Morning Dew Court 21029 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Xes 2 No Black, White, etc. à 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates, 1942-46 1 ☐ Yes 2X☐ No Specify. Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) the Optician Optometry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental 1 pe h Frederick Leo Wittkamp Florine Perry . Page 1 and 2 should ment of Health and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.s</u> Jocelyn O<u>'Neill/Daughter</u> мр 21029 6326 Morning Dew Ct other Clarksville Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State Dec Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Baltimore, 22. Name and Address of Facility
Francis J. Collins Funeral Home
FOO University Blvd. W., Silver 21, Signature of Funeral Service Licensee Inc. 500 University 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Aspiration Pneumonia Medical resulting in death) Due to (or as a consequence of) **Examiner** Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): e burial-transit Examin Chronic Kidney Disease certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Congestive Heart Failure as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for that the death Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas autopsy page certificate 1 Yes 2 No ☐ Yes 2X XNo 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: Assisted 2X No Living 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral 27, Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 ANatural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Coffifyling Nurse Vacationer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29d. Date signed (Month, Day, Year) 3+1 Jerge D005327 2010 who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Peter

31. Date filed (Month, Day,

F.

Stengel,

06

MD

Registrar's Signature

7525 Greenway Center Drive,

Greenbelt,

MD 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 12 2010 12:40 PM Mary E. Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Care 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 6/8/1936 1 M 2 STE Days Hours Min Months 74 Yrs. **Director** 217-30-2782 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8610 Snowden River Parkway #105 21045 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: "natural", Completed 3 XWidowed 4 ☐ Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bertha May Kettleband Raymond Kircher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. 200 Frazier Ct., Joppa, MD 21085 Brenda Bartha / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 12/9/2010 Woodlawn, MD 4 ☐ Denation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. . Signature of Funeral Service M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Pyr. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, srr. ck, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Chronic distribution disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23h Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death as been signed by the a 2 should be detached 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page performed? Yes 2 X No certificate 1 Yes Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) WOS () Col 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director: After X Natural iniury work?
1 Yes 2 No 5 Pending 2 Accident Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Vecember 6 2010

Registrar
DHMH 17 Rev 7/2009

State

10

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

670

N. Charles

TOWSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

DEC

w

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mabel F. Walstrum M2nth 05-2090 Physician 0815 A /Medical 4c. County of Death 4b. City, Town, or Location of Death Rising Sun 4a. Facility Name (If not institution, give street and number)
Calvert Manor Nursing Home Examiner If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 92 yrs 8. Date of Birth 5. Social Security Number 215-07-2686 **Funeral** Days 0 Month Day, 9998 1 □ M 2 🛚 F Marilland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Show 1 ☐ Yes 2 No ortant; If item 27 is marked other than "natural", or items 23a or 28a-f st injury or other traumatic event, <u>the Medical Examiner must be notified</u> Maryland Cecil Director Port Deposit 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 East Circle Drive 21904 United States of America 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No White Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Sacondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygien Important: If item 27 is marked other tra any injury or other traumair. Family 17. Father's Name (First, Middle, Last)
Frank U. DeBaugh 18. Mother's Name (First, Middle, Maiden Surname) Be Ada Sampson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie L. Mullen (daughter) P.O.Box 16, New London, Pennsylvania 19360 20b. Place of Disposition (Name of cemetery, crematory or other place)
RA Ferris ECO, Inc 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12-06-2010 West Chester, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Sorv 22. Name and Address of Facility Z Iman Funeral Home. P. A. 123 S Washington St, Havre de Grace, Maryland 23a. Part1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Rena 1 month /Medical Due to (or as a consequence of): Examiner Imout My Ocar dial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred P Hospital or Attending P 24 hours after death. Funeral Director: After t Certification: 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101

THE SOUTH

10028324

Rising

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
	1 - State Registrar Certificate of Death Reg. No U 4 U 2 U
Physician/ Medical	1. Decedent's Name (First, Middle, Last) WAYNE EDWARD WAUGH 2. Date of Death Month Day Year 1. OP A
Examiner	4a. Facility Name (if not institution, give street and number) CIVISTA MEDICAL Center 4b. City, Town, or Location of Death Charles
Funeral Director	5. Social Security Number 577-40-5186 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
ne Maryland or 28a-f show notified at	Usual Residence of Decedent 10a. State
leath with the litems 23a or 2 er must be no Funeral Di	10e. Street and Number 11122 COMMANDERS LANE 10f. Zip Code 10g. Citizen of What Country? U.S.A.
0 1.9	1 Never Married 2 Married 1X Yes 2 No ARMY Mes, specify duals, tries, specify duals,
Maryland 21215-0036 2 should be filed within 72 hours after it and Mental Hygiens 77 is marked other than "natural", o traumatic event, the Medical Exam To Be Completed by	
rland 2	17. Father's Name (First, Middle, Last) GEORGE ALLEN WAUGH 18. Mother's Name (First, Middle, Maiden Surname) EDNA ORA HILL
Mary d 2 should alth and N 127 is ma or trauma	19a. Informant's Name/Relationship (Type, Print) WILLIAM WAUGH-SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 CORNWALL COURT LA PLATA, MD. 20646
Baltimore, permit. Page 1 and Department of Hea mportant: If item may injury or other pine.	20a. Method of Disposition X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of Date 12-22-10 AD Cerretery Crematory Contemplace) AD CETTERANS CEM. Date 12-22-10 CHELTENHAM, MD.
Ball permit Depart Impor any in	21. Signature of Emeral Service Licensee M00479 AYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. The failure is a such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ARCITYON ARCITY Approximate Interval Between Onset and Death ARCITY August 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death ARCITY Approximate Interval Between Onset and Death ARCITY Approximate Interval Between Onset and Death ARCITY Approximate Interval Between Onset and Death ARCITY Approximate Interval Between Onset and Death ARCITY Approximate Interval Between Onset and Death ARCITY Approximate Interval Between Onset and Death ARCITY Approximate Interval Between Onset and Death ARCITY Approximate Interval Between Onset and Death ARCITY Approximate Interval Between Onset and Death ARCITY Approximate Interval Between Onset and Death ARCITY ARCITY Approximate Interval Between Onset and Death ARCITY ARCITY Approximate Interval Between Onset and Death ARCITY ARCIT
te be executed ivisician and he burial-transit dical Examiner	
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be e- 24 hours affer death. Funeral Director: After this certificate has been signed by the attending physician sted filled in by the funeral director, page 2 should be detached for use as the buri- edical Certificate: To Be Completed by Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 2 we 2 we No 9 we Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year 2 we Year Year 2 we Year
ords, P.O. Be requires that the deben signed by the should be detached should be detached by Physioleted Physio	Zee. Did (bbacco use contributing to death but not resulting in the underlying cause given in 1 art.)
Records, The law require rate has been si page 2 should the	24a. Was an autopsy findings available prior to completion of cause of depending and part of the completion of cause of depending and depending and cause of depending and depending and depending and depending and depending and depending and depending and depending and depending and depending and depending and depending and depending and depending and depending and depending and
Vital Reconviscian: The law in certificate has built director, page 2 s	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director. After this certificate has been signompleted filled in by the funeral director, page 2 should be Medical Certificate: To Be Completed	The inflation 2 is a residence of inflation of the inflat
Division A vital or A vital or A vital or A vital Direction by alled in by all Certain	
To the Hospita Within 24 hours To the Funeral completed filled	29a. Certifier (Check 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
F 3 F 0	
Chal	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Corce WATHEN, MD 11.3.45 Pemorcoke Square Suite 103 WALDORF, MD 20 31. Date filed (Month, Porter) 2 0 2010 32. Registrar's Signature Square Suite 103 WALDORF, MD 20 32. April 10.
State Registrar DHMH 17 Rev 7/2009	DEC 20 2010 Lener B. Jack
DHMH 17 Rev 7/2009	ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State	State of Maryland		artment of H			2010	1.0201
			Registrar 1. Decedent's Name (First, Middle, Last)		061	incate of b	catii	2. Date of Death	eg. Nø. U U	3. Time of Death
	Physicia		HEL	EN LOUIS	F	WEBB		Dec. 1	O. 2010	11:30 A ^M
	Medic Examin		4a. Facility Name (if not institution, give s		allouf	4b. City, Town, or	Location of Death		4c. County of Death	
Sec. 100	1		2101 Jerrys 1	Road			Street		Har	ford
	Funeral		5. Social Security Number 6. Sex	THE ONE !		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		9. Birth	place (State or Foreign
	Director		212-24-9738	84	Yrs.			6/11/71	926	Maryland
	nd how at	٦ ا	10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	taryla 3a-f s iffied	ect.	MD. Hari	ford		5	Street			1 ☐ Yes 2X No
	or 28	Ē	10e, Street and Number			10f. Zip Code		11	0g. Citizen of What Cou	ntry?
	s 23a uust b	Funeral Director	2101 Jerrys I	Road		2]	L154		United S	tates
	death item item		Titi Mariar Gratag	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
36	after l", or xamir	d b	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give		Yes 2 No				hite
8	ours atura cal E	Completed	15. Decedent's Edi	Year or Dates.	16a Decer	lent's Usual Occupa	ation		16b. Kind of Business Ir	
15	an "n Medi	ם	(Specify only highest grade Elementary/Seconday (0-12)		(Give	kind of work done d O NOT use retired)	uring most of wor	king	TOD. KING OF Edeliness II	ladairy
21215-0036	withir giene er th		11	O College (1-4 or 5+)		Farmer			Farm	ing
pu	be filed within 72 hours after death with the Maryland ental Hyglene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle, M		
yla	Ment Ment narke	욘		Alexander	Bad	ders	Wil	lie	Dean F	ruett
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Typ						City or Town, State, Zip	
	and 2 s Health tem 27 ther tra		Steven C. Webb 20a. Method of Disposition	(Son)		Jerrys sition (Name of			t, Maryla 20c. Location - City or T	
Baltimore,			1 Durial 2 Cremation 3 4 Donation 5 X Other (S	Removal from State	metery, crer	natory or other place		シェ エフョ		
Ē	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Arvice License		-	Mem. Gal			Bel Air, tz & Son	
Ba	permit Depar Impor any in once.		1 11. Hackley	Kurt I	-	ome. P.			ille, Mar	
			23a. Part 1. Enter the disease, or compl	ications that caused the death.						Approximate
Ь,	Pnysician/		shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on eachilyle.	in ic				1	Interval Between Onset and Death
	Medical		resulting in death)	Due to (or as a conseque	ence of):					
	Examiner	Ļ	Sequentially list conditions,	Diubetes M	ellitu	5				
	p #	Examiner	cause. Enter Underlying	Due to or as a conseque	ence of:					
	ecuted and Il-transit	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
	te be exe hysician a he burial	dical E	Tooding in doding 2000							
200	cate phys			d						
89	ath certifica attending p	/u	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnan	су]e			23d. Date of deliv	very
Box 687	e atte	sicia	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 Live Birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnance Other (specify)	у		Month	Day Year
O. E	the c by the tache	Physician/Me	9 🗆 Unknown	9 LJ Unknown						
P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions con	ntributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.		acco use contribute to	_
rds	equire een si ould I	ted	Absen Hip	MINSA				1 ⊔ Ye	s 2 ⊠ No 3 □ Pro	
ō	law re nas be	Completed by	Osteoporosis					24a. Was an autops perform	y prior to co	opsy findings available ompletion of cause of
of Vital Records,	The law icate has page 2 s							1 🗌 Yes 2		2 No
ital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital:		1 Othe	ace of Death (Che er:			
<u></u>	Physic this eral di	e: To	27. Manner of Death	1 Inpatient 2 E	28b. Time of	nt 3 🗆 DOA	4 ☐ Nursing F	lome 5 X Resider 28d. Describe how	nce 6 Other (Specif w injury occurred	ý)
'n	Attending P death. ctor: After t y the funera	icat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work'	? Yes 2 □ No			
Division	I or Atter after dea Director	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rura	Al Route Number,
Š	ital or A irs after al Direc led in by	C	<u> </u>	Building, etc. (opecity)				City of Town,	State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 424 hours after death. To the Funerial Director, Refer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check 2 Medical Examin	cian: To the best of my knowle er: On the basis of examination	and/or inves	tigation, in my opinio	n, death occurred	at the time, date and	place, and due to the ca	ause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of my	knowledge,	29c. License	-		eause(s) and manner as solution. Od. Date signed (Month,	
			> Aly Nag	1. MD		D004	59387	1	2/10/2010	
	•		30. Name and address of person who co		4	Print)				
			, , ,	Colgate Drive	, ,		, MD Z	1050		
	Sta Registra	e ar	31. Date filed (Month, Day, Year)	20 0 Registrar's Signatu	A.	barker				

OHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Den 1 - State Amend Item 25 per me, g910, 12/1	artment of Health and 7/2010dhb	Mental Hygie	ne
	_		Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg.	- CUIUTHUZUZ
	Physicia		Carlos Augusto Yabiku			Day Year 9:35 A M
	Medid Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	j.		Prince George's Hospital	Cheverly		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	8. Date of Birth	9. Birthplace (State or Foreign	
П	Director		579-78-15,31 1 M 2 □ F 59 Yrs.	Months Days Hours Min.	(Month, Day, Yea 5/21/19	Distriction Country) Lima, Peru
	ld now at	<u>-</u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	arylar a-fsh fied a	[윷	, , , , , , , , , , , , , , , , , , , ,			1 ☑ Yes 2 ☐ No
	or 28; notif	Director	MD Prince George's Bladensbu	10f. Zip Code	100	. Citizen of What Country?
	with til 23a c	ial	5436 Taylor Street	20710	109.	USA
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp		14. Race - American Indian,
9	fter de , or it amine		1 ☐ Never Married 2 🛭 Married Armed Forces? 1 ☐ Yes 2 🗔 No	If Yes, specify Cuban, Mexican, Puerto		Black, White, etc.
8	ursaf urral" al Exa	Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☑ Yes 2 ☐ No Specify:	Peruvian	Specify: Japanese
5	72 ho	oldu	(Give	edent's Usual Occupation e kind of work done during most of wor	king 16t	b. Kind of Business Industry
4	thin 7	Son	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired) untant		mtrak
d 2	Hygiw Hygiw other ent, t	Be (17. Father's Name (First, Middle, Last)		ne (First, Middle, Maio	
Maryland 21215-0036	be fil ental rked ic ev	욘	Momatzu Yabiku Izu		abiku Toba	,
ary	nould Ind M s mai	II. 3	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Ru		•
Σ	d 2 sl alth a n 27 i ertra			Taylor Street, B		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Disposerery, cre	osition (Name of matory or other place)	Date 20d	c. Location - City or Town, State
<u><u>ŭ</u></u>	Page nent ant: I ury o			itan Crematory 11/	8/2010 A1	lexandria, Virginia
3alt	permit. Departimport Import any inj		21. Signature of Funeral Service Licensee	2. Name and Address of Facility	4	739 Baltimore Avenue
	ಪರ್ವಹಕ	9	Tems Hutman G	asch's Funeral Ho	me, P.A. H	yattsville, MD 20781
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	nysician/		Immediate Cause (Final disease or condition	ng		Onset and Death
	, Medical Examiner		Due to (or as a consequence of):			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		A. M.)
	ed nsit	min	cause Enter Underlying Cause (Disease or iinjury Appendicitis		Je Jus	AMINER
	xecu n and al-tra	Exa	that initiated events c. Due to (or as a consequence of):	1 1	BONED BY MEDICAL	
09	ate be executed physician and the burial-transit	dical Examiner	C Sepsis	CERNEICATIONAPP	ROVED BY MEDICALEX	
376	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	IF FEMALE:	9		
Ö	endir r use	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of delivery
Bo	death	sici		Other (specify)		Month Day Year
P.O. Box 687	at the	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	00- 5-11-1	
π, σ.	es tha	Completed by Physician/Me	Acute brainstem stroke, Bilateral pn			co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
rds	requir been thould	etec		- dinonita y		
000	has k	ldm	Respiratory failure		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ř	n: The icate r, pag		25. Was case referred to medical		1 ☐ Yes 2 🗶	
/ita	Physician: The lav r this certificate has aral director, page 2	Be	examiner? Hospital:	26. Place of Death (Chec	, ,	
) t	Physer this eral d	e: To	27. Manner of Death 28a. Date of injury 28b. Time of	nt 3 ☐ DOA 4 ☐ Nursing H	ome 5 L Residence 28d. Describe how in	e 6 Other (Specify)
n C	ath. :: Afte	icat	1 ☒ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		,,,,,
<u>s</u>	Atter	Certificate:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office		and Number or Rural Route Number,
Division of Vital Records,	tal or rs afte al Dir ed in		building, etc. (Specify)		City or Town, St	ate)
	lospi 4 hou uner ed fill	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or invertible.	occured at the time, date and place, a	nd due to the cause(s)) and manner as stated.
	the thin 2, the F	Me	only one) 3 L Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the time, date and pla	ce, and due to the caus	se(s) and manner as stated.
	5 № 6		29b. Signature and title of certifier ASI.	29c. License number	Q 29d.	Date signed (Month, Day, Year)
			TOUR PORTS	M D006033	7 1	1 04 2010
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Khalid Hassan Ashai, 7525 Greenway Co	,	303 000	enhelt MD 20770
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature		JUJ, GLE	CHOCLE, FID ZU//U
	Registra		DEC 1 7 2010 June B. 4	backer		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 5, 2010 Physician/ Iris Voss Yonetz 4:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick 602 Schley Avenue Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 😾 F Hours Min. Nov. 10, Year 1921 North Carolina Yrs **Director** 242-28-2541 89 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 United States 602 Schley Avenue death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 721 (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. the Bookkeeper Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk.) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. Elizabeth James Voss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prospect Road, Mount Airy, MD 21771 James Yonetz / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Date cemetery, crematory or other place) 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Resthaven Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signatur of Funer Service ²² Name and Address of Facility Restnaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear failure. List only one cause on each line.

Immediate Cause (Final Find Stage Chronic Obstructive Pulmonary Dise Onset and Death Physician/ End Stage Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ner Due to for se a noneequence on Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No ò 5 Other (specify) Month Day Year Yes sate has been signed by the page 2 should be detached 9 Unknown Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 XX No 1 Yes completed filled in by the funeral director, å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 21944 December 7, 2010 MY

Registrar

State

#204, Frederick, MD 21702

1475 Taney Ave.,

32. Registrar's Signature

LEMBUR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Grissom,

James S.

31. Date filed (Month, Day, Year,

0-09118		Please Type or Print in Black Indelible Ink. Ensure All C		gible.	
.exi Regina Ziri	nsky	out of the first o	ital Hygiene	20	10 1.00
		Registrar		Reg. No.	10 402
Physici			2. Date of Dea Month	ath Day Year	3. Time of Death
Medical Exam	ıner	Lexi Regina Zilinsky		r 28, 2010	0707 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	of Death	4c. County of Deat	h
		415 W. Potomac Street Brunswick		Frederick	
Funeral				rth (MM/DD/YYYY) 9. Bio	thplace (State or Foreig puntry)
Director		None 1 M 2XF 0 Yrs. Months Days Hours	s Min. Sept.	29, 2010 M	aryland
		Usual Residence of Decedent			
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
nd show	>	Maryland Frederick Brunswick			1 X Yes 2 No
Maryland 28a-f show d at once.	ecto	10e. Street and Number 10f. Zip Code	1	l0g. Citizen of What Cou	ntry?
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Director	415 W. Potomac Street 21716		United St	ates
s 23s		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Control Original Control of Hispanic Original Control Origin	gin? (Specify Yes or No		ican Indian, Black,
eath y item ust b	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican		White, etc.	
ter de ", or		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: W	hite
urs af tural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give		16b. Kind of Business/	
2 hou	jec	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT			•
36 hin 7 than edica	ğ	0 None		non	e
15-0036 filed within 72 hours a: 1 Hygiene. cd other than "natural t, the Medical Examin	Completed		's Name (First, Middle,		
215 e file al H.	Be (Jason August Zirinsky	Jessica P	eavv	
21215-0036 wald be filed within 7 Mental Hygiene. marked other than c event, the Medica		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num			. Zip Code)
and and ati		Jessica Peavy / Mother 415 W. Potomac St			
e, M 1 and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
Ore ges 1 rof H		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	December		
tant		4 Donation 5 Other Specify: Frederick Crematory		Frederick,	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		21. Signatum of Funeral Service Licensee 22. Name and Address of Facility			
	2 1	1621 Opossumtow			
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c failure. List only one cause on each line.	ardiac or respiratory am	est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediete Cause (Final disease a Multiple Injuries			Death
A [#]		or condition resulting in death) Due to (or as a consequence of):			
	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Ë	cause. Enter Underlying Cause			
	Examiner	events resulting in death) Last Due to (or as a consequence of):			
executed in and il - transit		d			
ੂਲ ਲੈ ਕ	gi	UNPENDED AMENDED			
Box 68760, e death certificate be the attending physic ed for use as the bur	ĭĕ	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delivery	,
ox 687 eath certific attending j	jan	past 12 months? 2 Fetal death 3 Ectopic	pregnancy	Month [Day Year
Box e death the atter ed for us	Sic	1 Yes 2 V No 9 Unknown 9 Unknown		1	
D. B. t the de by the ached f	Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	rt I. 23e. Did to	obacco use contribute to	the cause of death?
ords, P.O. w requires that the as been signed by should be detach	ρ			s 2 No 3 Prob	
fs, quire en sig	ompleted		24a. Was		topsy findings available
COTC law re has be	휣		autop		ompletion of cause of
Rec The I	팃		1 Yes		s 2 No
Vital Rec sysician: The his certificate director, page	BeC	25. Was case referred to medical 26. Place of Death examiner?			
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the fineral director, page 2 should be	9	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	Nursing Home 5	Residence 6 🗹 Other	: Scene
ision of Attending Pher tractor: After by the funeral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work 1 Natural 5 People FOUND: 1 Ves 2 M	? 28d. Describe I Subject ass	how injury occurred	
ion tendi	ertification:	1 Natural 5 Pending FOUND: 1 Yes 2 ✔ 2 Accident Investigation Nov 28, 2010 0700 hrs	No Subject ass	auited	
ViSi or At fler d in by	ij	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		Street and Number or Ru	ral Route Number, City
ortal Distal	e	4 Homicide determined (Specify) Single Family Home	or Town, S 415 W. Poton	nac Street, Brunswick	, MD
Hosp 24 ho Fune tely f	<u>ا</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time, date	and place, and due to the	e cause(s)
- F. S. E. S.	₹	29b. Signature and title of certifier / 29c. License number		29d. Date signed (Mor	nth, Day, Year)
		Carol Hell Cav O.C.M.E.		November 29, 20	110
	ŀ	30. Name and address of person who completed cause of death (Item 23a)	· · · · · · · · · · · · · · · · · · ·		
լ		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
S	ate	31. Date filed (Month Day, Year), 2010 32. Registrar's Signature			
Regist		TEC 8 2010 Census S. Sparker			

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Col State of Maryland / Department of Health and Mental Amend Items 27,28a,b,d,e,f,per me,g910,12/21/2010d Certificate of Death	
1. Decedent's Name (First, Middle, Last) 2. Date	of Death 3. Time of Death
Physician/ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	2 Pay Year /3 OP M 4c. County of Death
Balteman Washington Medial Centre EHAN BURNIE	Anne Arundel
Funeral Director 5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 AM 2 F 7. Age (In yrs. last birthday) 1 Yrs. Months Days Hours Min. Usual Residence of Decedent	of Birth 9. Birthplace (State or Foreign h Day, Year) A PORCH
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
To a State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. Street and Number 10c. Street and Number 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location 10c. Street and Number 10c. City, Town or Location	1 ☐ Yes 2 No 10g. Citizen of What Country?
The set of the set of	No- 14. Race - American Indian,
Affiled Forces, If Yes, specify Cuban, Mexican, Puerto Rican, etc	Black, White, etc. Specify: \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\
Secondary (0-12) 1	16b. Kind of Business Industry
College (1-4 or 5+) Elementary/Seconday (0-12) College (1-4 or 5+) Fig. Do Not use retired A Mother's Name (First, Middle, Last)	Pile Driving
Tr. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19. Mailing Address (Street and Number or Rural Route Name) 19. Mailing Address (Street and Number or Rural Route Name)	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route No. 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	imber, City or Town, State, Zip Code)
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20c. Location - City or Town, State
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signatur of Fineral Service Linesee 22. Name and Address of Facility Daug Particular (Specify)	ety Funeral Home
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each lin.	POSOCIOO, MD 21122 py arrest, Approximate
Ph. sician/ Medical Immediate Cause (Final disease or condition resulting in death) a	Interval Between oper and Death
Examiner Overviol	
cause. (Disease or injury that initiated events	Pulaga
	A Kiz
d	23d. Date of delivery
d. Comparison of the content of t	Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Did tobacco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Yes 2 No 3 Probably 4 Unknown Was an 24b. Were autopsy findings available
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25e. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25e. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	☐ Yes 2 No 3 Probably 4 ☐ Unknown
d. Comparison of the companies of the	Was an autopsy findings available prior to completion of cause of death? Yes 2 No 2 No 1 Probably 4 □ Unknown Yes 2 No 2 No 1 No 1 No 1 No 1 No 1 No 1 No
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. I 24a. 1 24a. 1 24a. 1 25e. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Injury at work? 28d. Description of injury 28d. Dispression o	Was an autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. I 24a. I 24a. I 25e. Was case referred to medical graphing of the property of	Was an autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No No No Note: Residence 6 Other (Specify)
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. I 23e. I 25e. I	Was an autopsy findings available prior to completion of cause of death? Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N
The state of the s	Was an autopsy and autopsy findings available prior to completion of cause of death? Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Residence 6 Other (Specify) ibe how injury occurred Unknown Complete and Number or Rural Route Number. Complete and place and due to the cause(s) and manner stated
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. 1 24e. 24	Was an autopsy and probably 4 Unknown Was an autopsy berformed? Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No Residence 6 Other (Specify) ibe how injury occurred Unknown Or Street an Number or Rural Route Number, State) 400 Unit of the Cause(s) and manner as stated. at eand place, and due to the cause(s) and manner stated. to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State-orivia	ryland #Bepa Cel	annemon tificate of l			giene _{Reg. No} 2	1,0206
	D 1		1. Decedent's Name	(First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physicia Medic			d Anderso					Novembe	er 30, 2010	1"30 PM™
4,	Examir	er	4a. Facility Name (if n		· ·			r Location of Death	1	4c. County of De	George's
4000	Funeral		Prince 5. Social Security Nur	George's mbe runk 6. Sex	Hospital 7. Age	(In yrs. last birthday)	If Under 1 Year		8. Date of Birt	h 9. E	Sirthplace (State or Foreign Country) unk
	Director		232-68-12	.55 ¹ X	M 2 □ F	68 Yrs.	Months Days	Hours Min.	Mar 10	Y, Year, 1942	Country) unk
	nd how at	٦	Usual Residence of D 10a. State	Decedent 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	// // // // // // // // // // // // //	ecto	DC 1	none		Washi	ngton				1 ☐ Yes 2🌠 No
	the N or 28	Ϊ́	10e. Street and Numb				10f. Zip Code			109. Citizen of What	Country?
	h with 1s 23a nust k	Funeral Director	606 Po	whatan Pl				20011		US	A
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show et than Medical Examiner must be notified at	Completed by Fu	11. Marital Status1 ☐ Never Marries3 ☐ Widowed 4	d 2 Married	2. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give	o unk	Nas Decedent of H f Yes, specify Cuba I ☐ Yes 2 🙀 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Dlack
3-00	hours natura lical E	lete		15. Decedent's Edu		16a. Deced	lent's Usual Occup	pation -	unic	16b. Kind of Busines	7 106-7
218	nin 72 ne. :han "l e Mec	dwo	Elementary/Secon		College (1-4 or 5+	ilfo D	kind of work done on NOT use retired)	during most of wor	king		
d 21	filed within tal Hygiene.	BeC	unk 17. Father's Name (Fi	rst Middle Last)	K.		unk	18 Mother's Nar	ne (Firet Middle	Maiden Surname)	unk
lan	e d ad	횬	The action of Hairing (File	iot, modio, Edoty				10. Mother 3 Nat	ne (i iist, ivildale,	waden darname)	
Baltimore, Maryland 21215-0036	2 shoulth and 27 is rr		19 Clayormant's Nam Prince Co	Toney 18	gaT guard	ian 19606 3001	Powhatan Hospita	an pyum bere ^{r Ru} 1 Drive (awashing heverly	£617,700, Star , MD 2078	50 f Y e)
more,			20a. Method of Dispo 1 Burial 2		emoval from State	20b. Place of Dispo	sition (Name of natory or other plac	ce)	Date	20c. Location - City	or Town, State
Baltin	permit. Page Department of Important: If any injury or once.	0. A	21. Signal		////			toffigilitBoa MD 21		. Baltimor	e Street
المديدة	Pnysician/ - Medical Examiner		23a. Part 1. Inter the shock, of heart Immediate Cause (Fi disease or condition resulting in death)	failure. List only one	cations that caused to cause on each line. Due to (or as	the death. Do not ente				rest, Juliune	Approximate Interval Between Onset and Death
		iner	Sequentially list cond if any, leading to inni- cause. Enter Underly	ving	Due to (or as a	cursequence of):	-	All	900	5	
	cate be executed physician and s the burial-transi	I Examiner	Cause (Disease or iin that initiated events resulting in death) La	njury	Due to (or as a	consequence of):					
209	ate be physic the bu	edical		d			_				
Вох 68	death certifi ne attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pi in the past 12 mo 1 Yes 2 U 9 Unknown	onths?	ic. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	cy		23d. Date of c Month	delivery Day Year
	The law requires that the ate has been signed by the page 2 should be detach		Part II. Other signific	ant conditions con	ributing to death bu	t n o t resulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	Y	to the cause of death?
cord	≥ 38 ≤	Completed by							24a. Was autop	osy prior t	autopsy findings available o completion of cause of
- B	sician: The certificate rector, pag		25. Was case referred	to medical			00 0	land of Dark (Ohn)	1 🗌 Yes	rmed death 2 No 1 □ Y	res 2 🗆 No
Vita	ysicia s certi directo	To Be	examiner?		espital:	nt 2 ER/Outpatier	Tout	er:		ience 6 🗆 Other (Sp.	ecifu)
on of	nding Phy ath. :: After thi e funeral d		27. Manner of Death 1 Natural Accident	5 Pending	28a. Date of injury (Month, Day,	28b. Time of	28c. Injur work	y at	I	ow injury occurred	sciny)
Division of Vital Records,	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or F rn, State)	Rural Route Number,
	he Hospit in 24 hour he Funera pleted fille	Medical		Medical Examine	r: On the basis of exa	amination and/or invest	igation, in my opinio	on, death occurred	at the time, date a	use(s) and manner as s nd place, and due to th e cause(s) and manner a	e cause(s) and manner stated.
	Vith to the		29b. Signature and titl	le of certifier		-	29c. License	e number		29d. Date signed (Mor	nth, Day, Year)
			30. Name and address	s of person who con	pleted cause of dea	ath (Item 23a) (Type, F	rint)		erly,MD	20785	10
			Demetrio 31. Date filed (Month,		T.	3001 Hospi	LCAL Driv	e cnev	erry, Fid	20103	
	Stat Registra		TFC	2 1 2010	32. Registrar	s Signature	Les .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alston Minnie Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death 4 ltmor Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Hours S' Carolina **Director** "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 ☐ No timol 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married by 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 o 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Be P Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number Method of Disposition 20b. Place of Disposition (Name of Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral survice Lice see 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Kidney cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Directo (or se a consequence of) If any Isaam a to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

MSRAMMAN () 29d. Date signed (Month, Day, Year) 29c. License number DO057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 Snith Av. 5- ZU3 - Baltimore, MD. 21209 S. Rajapakse, M.D. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month ecemi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** mor If Under 24 Hrs. Hours Min. Age (In yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 V F Months Mountry) Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 I No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt 20 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status 12 Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory 4 Donation 5 ☐ Other (Specify) . Sign 🔰 😁 Funeral Service Licens 😸 Name and Address of acility Joseph L. Russ 2222 W. Nort Part 1/ Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Phylician eu Kemia disease or condition resulting in death) TWO YEARS Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached filled in by the funeral director, page 2 should be detached filled in by the funeral director, page 2 should be detached filled in by the funeral director, page 2 should be detached filled in by the funeral director, page 2 should be detached filled in by the funeral director, page 2 should be detached filled in by the funeral director. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death 9 I Inknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv perform death? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 5 Residence 6 Other (Specify) မှ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury 1 Natural 5 Pending 2 \square No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year) 005239 December 20 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) M 21231 Street Orleans Date filed (Month, Day, Year)
DEC 2 1 2010 State Registrar

DHMH 17 Rev 7/2009

10-09334 Carolyn*Ashley

Funeral

Director

iny

show

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", ur items 23a nr 28a-f shu injury nr other traumatic event, the Medical Examiner must be morified at a constitution.

Baltimore, MD 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 010 40209 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3 Time of Death Month Day December 5, 2010 Medical Examiner 0101 hrs Carolyn Ashley 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number 11nk 6. Sex If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) 9. 8irthplace (State or unk 8. Date of Birth (MM/DD/YYYY) oreion Months Days Hours Jan 25, 1945 1 M 2X F 65 Country) Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Baltimore Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 W. Belvedere Avenue #1013 21215 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify. black Specify: ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of 8usiness/Industry unk Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD O.C.M.E. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation & Other Specify: in state 21. Signature of Function Service Licenses de Director State and Address of Gaod Board 655 W. Baltimore Street 21201 Baltimore, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 8etween Onset and Death Immediate Cause (Final disease a Hypertensive atherosclerotic cardiovascular disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): an/Medical X UNPENDED AMENDED, PII, 27, per ME g910 12/27/10 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year past 12 months?

Physician /Medical Examiner

> and attending physician for use as the burial signed by the atto be detached for Compl certificate page Be this ٩ After Certification: Director:

25. Was case referred to medical

2 No

5 Pending

Investigation

Could not be

determined

examiner?

1 🗸 Yes

27, Manner of Death

1 X Natural

2 Accident

3 Suicide

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

after death

within 24 hours a

To the Funeral I

completely filled

Medical

Division of Vital

Records, P.O. Box 68760.

hysic	- John John
γP	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par
d b	Chronic alcohol abuse
eted by	

			24a. Was an autopsy performed?	prior to completion of cause of death? 1 ✓ Yes 2 No
and the same of th		26 Place of Death (Check	(only one)	et en en en en en en en en en en en en en
^{tal:} 1 Inpatient 2 ✓	ER/Outpatient 3	DOA Other Nurs	ing Home 5 Residence	ce 6 Other:
28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury	y occurred
28e. Place of Injury - At h (Specify)	nome, farm, street, factor	y, office building, etc.	28f. Location (Street and or Town, State)	d Number or Rural Route Number, City

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)		
and manner stated.		
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Calmert 10	O.C.M.E.	December 5, 2010

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Hospital: 1 Inpatient 2 V ER/Outpatient

Registra

31. Date filed (Month, Day, Year)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 16, 2010 4:40 A M Richard Joseph Alfultis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Renaissance Gardens If Under 1 Year | if Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Missouri 8. Date of Birth Month Day, Year) June 29, 1928 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🔀 M 2 🗆 F 82 Director 491-26-9240 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3118 Gracefield Road #107 United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 by Yes 2 □ No If Yes, Give 1046—1048 Year or Dates. 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 In and Mental Hygiene. Federal Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Coordinator Government Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Henry Owen Alfultis Sarah Barnhill other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i 11104 Ardwick Drive, N. Bethesda, Maryland 20852 Lisa A. Zingone/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 19, permit. Page 1 a Department of H Important: If ite any injury or otl 1 Burial 2 🛣 Cremation 3 🗌 Removal from State Montgomery Crematorium, Inc. 2010 Bethesda, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Licensee Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue Loy M01498 23a. Part 1. Efiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner 2 weeks Abdominal Abscess Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 9 Unknown a 🗆 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Diabetes Mellitus autopsy performed? Yes 2 X No death? 1 ☐ Yes 2 ☐ No this certificate Peripheral Arterial Disease 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 😿 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) December 16, 2010 D24093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 3110 Gracefield Road, Silver Spring, Maryland 20904 Mark Parkhurst, 32. Registrates Signature State Registrar

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mildred E. Aerni 2010 December 4:30PM Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Hamilton Nursing Center Baltimore City n/a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, January 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 I 220-07-3256 91 Country) New York Director 1919 Usual Residence of Decedent 28a-f shov 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1933 Main Avenue 21122 U.S.A. death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Completed Specify: White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker Crown, Cork & Seal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Morton Edwards Josephine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1933 Main Ave. Pasadena, MD 21122 Margaret M. Homberg - Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dec. 18,2010 Hilltop Services Towson, MD 22. Name and Address of Facility Leonard J. Ruck 5305 Harford Road Baltimore Maryland 21214 21. Signatura of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, TAGG disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events -tran and Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Year Day Pregnant at time of death 2 No To the Hospital or Attending Physician: The law requires that the dewinthin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion or death? performed? Yes 2 No 1 Yes 25. Was case referred t edical examiner? 26. Place of Deat heck only one) Hospital 2 No 1 Tyes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur rson who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year AM -harles 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kline Frederick HOSpice MT. Air Social Security Number If Under Birthplace (State or Foreign Country). 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Hours 1 🕅 M 2 🗆 F Days ^{Year)} 1918 Yrs **Director** Pennsylvania 92 201-07-9461 Aug or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25205 Conrad Court 20872 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Pressman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Baker Helen Μ. Werkheiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda M. Hrenko/daughter 25205 Conrad Court Damascus, Maryland 20872 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/20/2010 Woodbine, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 homas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each ine Immediate Cause (Final neumoni a Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Hinknown Part II**. Other significant conditions,**contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ailen 1 Yes 2 No 3 Probably 4 Unknown Completed mentia 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence State (Specify) HOSPICE 1 ☐ Yes 2 ☑ No Hospital: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 2 🗌 No ☐ Accident ☐ Suicide Investigation 24 hours after deatl Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

State Registrar

only one)

29b. Signature and title of certifier

Syed W. Haque,
31. Date filed (Month, Day, Year)

DEL 2 1 ZUIU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Jank

700 Montclaire

32. Registrar's Signature

29c. License number

Avenue

Frederick, Maryland 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Midgle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:15 Medical ZGM31 2010 **Examiner** ity, Town, or Death County of Death 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 04 08 1 🗆 M 2 🗶 F Months Hours Min Director 92 Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2. No Anne Arundel Pasadena 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8463 Garden Road 21122 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ■ No permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Philip Reinhardt Marian Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Tamburo - Nephew 8463 Garden Rd. Pasadena, MDinjury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cem | 12/21/10 Baltimore, MD 22. Name and Address of Facility GJ Gonce Funeral Home 21. Signature of Theral Service Licenses 169 Riviera Drive Pa<u>sad</u>ena, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami vate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed I or Attending Physician: The after death. 2 10 Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No ပ္ Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Skiron MINICAL

Registrar

DHMH 17 Rev 7/2009

State

BRAWNER

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18^{Day} Physician/ Dec. 2010 11:10AM <u>Clara</u> Jean Burris Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's County Hosp. Prince George's Cheverly Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2X□XF Min. 06-19-68 250-37-9274 42 Hours Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important if item 27 is marked other than "natural" or hours any injury or other trainmetra. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits York SC Rockhill 1 A Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1041 Bose Avenue 29732 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian,
Black, White, etc. African
Specify: American Completed by 1 Never Married 2 XMarried 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Packer 12th Grade Manufactoring NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Calvin Wilson Stewart Jannie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Marcus Burris-Husband 1041 Bose Avenue Rockhill, SC 29732 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Liberty Hill 1 X Burial 2 \square Cremation 3 \square Removal from State 12-27-10 Rockhill, SC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one obuse on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be execured attending physician and for use as the burial-tra Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s r this certificate had iral director, page Yes_ 2 X No 2 💢 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X** No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 XDOA 4 Nursing Home 5 Residence 6 Other (Specify) : After thi Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Sulcide 5 Pending work? 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: All ompleted filled in by the fu Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 within 2

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certi D 68853 2010 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p MALIKA 3001 HOSPITAL 31. Date filed (Month, Day, Year) State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George John Benzing, Jr. 2010 December 20 2:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, June 26, 1 **Funeral** 9. Birthplace (State or Foreign 1 ★ M 2 □ F Days Hours Min. Months **Director** Mary Land 212-20-3069 1925 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Essex 1 ☐ Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 317 Stemmers Run Rd. 21221 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: WWII Specify: White 3 ▼ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George J. Benzing, Sr. Elizabeth Dorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Stemmers Run Rd. Essex, Catherine Benzing/ Daughter Md. 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 T Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 12-21-10 Towson, Md. 21. Signature of Funeral Service License ^{22. Name and Address of Facility}
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SMOKE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or immediate) Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the at be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s 24 hours after death.

Funeral Director: After this certificate has autopsy perform death? 2 No 1 ☐ Yes 2 ☐ No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Was Old 1 Natural Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 🗆 To the vithin 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier December 20 2010

Registrar

4+1

N Charles ST Tausen MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 1 Physician/ 2010 5:27 P Wells Velma Bowman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours (Month, Day, Year) an. 6, 1915 Virginia Director 231-24-3496 95 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1X Yes 2 No Carroll New Windsor 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 1038 Green Valley Rd. 21776 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany ones. Elementary/Seconday (0-12) College (1-4 or 5+) sales clerk retail gift shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dossie R. Barton Abraham R. Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 High St., New Windsor, MD 21776 Jeannie Laudermilch - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Pipe Creek Cemetery 12/23/2010 Linwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home 310 Church St., New WIndsor, MD 21776 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consectuence on attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day 1 Yes 2 No 9 Unknown as been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital 2-1 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No 1. Natural 5 Pending ☐ Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cert 29c. License number 20/6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) as WESTOWN STER C-OURISIAMENE NAUGINA 700A POOLE (31. Date filed (Month, Day, Year)
UEC 212010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OONE Physician/ Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Seasons Hospice 7. Age (In yrs. last birthday) 71 Yrs. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe **Funeral** Months Days Hours Min 1 🕅 M 2 🗆 F 219-26-9390 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10h. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Randallstown **Baltimore** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21133 Funeral 9903 Gunstock Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 filed within 72 hours after Specify: African-American 3 🗌 Widowed 4 🗎 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Self-Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H i item 27 is marked ot r other traumatic ever Lena Connor 1 and 2 should be fill of Health and Mental item 27 is marked (ဥ George H. Boone Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 152 Parsons Lane, Newton, PA 18940 Tamie Cotton/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition Department of H Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State Page 1 12/15/2010 King Memorial Park Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wille Funeral Inne P.A. of Balto. Co. 21. Signature of Funeral Service Licensee any 9200 Liberty Road, Randallstown, MD 21133 a Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, brock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ Unknown the Division of Vital Records, P.O. ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\sum \) No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other မ 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27, Manner of Death Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type 32. Registra State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 40218 David Harry Brimmer State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day December 13, 2010 1355 hrs Medical Examiner Brimmer 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Worcester 39 Moonshell Drive Ocean City 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Days Country) Hours Director 03/08/1938 227-46-1209 72 VA 1 X M 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 X No or items 23a or 28a-f show imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene and the Health and Mental Hygiene and the Iffice at 71 is marked other than "natural", or items 23a or 28a-f sho or other traumaric event, the Medical Examiner must be notified at once Tappahannock Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22560 447 E. Gwynnfield Road U.S.A Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year 3 X Widowed 1 Yes 2 X No specify: Specify. White à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) AT & T 12 Telecommunications Technician 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Brimmer Estelle Slaybough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 7286 Shannondale Road, Mechanicsville, MD 23116 Valerie Brimmer, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 X Removal from State Baltimo permit. Page: Department o 12/18/2010 Tappahannock, VA Essex Cemetery Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 entral Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Contact Gunshot Wound of Neck Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Ca UNPENDED AMENDED the attending physician led for use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? P.O. Š Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, s certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? page 2 performed? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical of Vital examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 🗸 Yes 28a. Date of Injury FOUND: 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death 28c. Injury at Work? Subject shot self Division **FOUND** Natural 1 Yes 2 ✓ No Director: d in by the f Pending Dec 13, 2010 1350 hrs 2 Accident filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 39 Moonshell Drive, Ocean City, MD determined (Specify) Driveway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 14, 2010 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BRONSON HAZEL 6:44 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CARROLL MOSPITAL LENTER WESTLINGTER CARROL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Days Hours Min (Month, Day, Ye an 21, Director 82 1928 New York 087-20-9136 Jan Usual Residence of Decedent 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important I frem 27 is amarked other than "natural", or items 23a or 28a-f sho important If item 27 is amarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 X No MD Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Apt 223 302 Cantata Court 21136 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Records Cord. Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) The1ma Allen William Lounsberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22999 S 199th Street Queen Creek, AZ John Bronson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 12/18/2010 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home 21136 Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPTIC SHOULE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MEUNON 13 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year Yes 2 No 9 Unknown by tacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2. No Other: ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No neral Director: A filled in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0027619 12.15.2010

State Registrar

DHMH 17 Rev 7/2009

1838 Greene Tree Road - # 420

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBENTELD

MF

31. Date filed (Month, Day, Year)

, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Frances L. Burl Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🕸 F 07/18/1921 Country) Director 216-18-4387 89 Virginia Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Maiden Choice Lane 21228 United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 X No Black, White, etc 1 Never Married 2 Married hours after ģ Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes Give White Specify: 3 Widowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Secretary Federal Government permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. LeBlanc Margaret Blackburne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Judith O. Lake (Friend)</u> 5010 Pilgrim Road, Baltimore, Marvland 21214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Dulaney Valley Memorial 12/23/10 Timonium, Maryland na re of Funeral Service LicerSee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Onset and Death Immediate Cause (Final Physician/ 10 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months2 Month Day Year Pregnant at time of death signed by the a d be detached t Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has birector, page 2 s autopsy death? 2 14 2 🗌 No 1 Yes Yes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 [[465 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Norsing Home 5 Residence 6 Other (Specify this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury s after dea. ral Director: After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c, License number 100 rson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day

2

Mard

10-09443 Reginald Coles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reginald Coles		State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Peg No. 201	022
Physicia	_	Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of	Death
Medical Examir		Reginal Coles December 8, 2010 Tear 1825	hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DD/YYYY) ate or	
Director		198-62-6899 1 M 2 F 45 Yrs. Months 303 1001 July 16, 1965 Country) +	14
in y	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside	e City Limits
Maryland 28a-f show any d at once.	۱ځ	mD NA Baltimore	s 2 No
Maryla	ac t	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
ith the 23a or notifie	Funeral Director	2422 Marbourne Ave Apt A 21203 USA 11. Marital-Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian,	Plack
eath w	ne	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc.	Black,
after d	by F	3 Widowed 4 Divorced in res, cive real 1 Yes 2 No specify: Specify	<u>د</u>
hours fratur Exami	Po	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
036 ithin 72 sne. r than '	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Behavioral Tech Healthcas	لك
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once.	Be ငိ	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NOLTER D. COLES 18. Mother's Name (First, Middle, Maiden Surname) Annie, Lee Floyd	ے
D 213 should b and Men 7 is mar!	P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7012
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	-	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
MOF Pages ent of nt: If		1 Depurial 2 Cremation 3 Removal from State crematory or other place) 4 Departion 5 Other Specify: 1 Departion 5 Other Specify: 1 Departion 5 Other Specify:)A
Baltimore, permit. Pages I at Department of Hee Important: If ite	4	21. Sign ture of Funeral San ice Licens (1) 22. Name and Address of Facility Howell Funeral	Horne
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardioc or respiratory arrest, shock, or heart Approxim	nate Interval
/Medical	4	failure. List only one cause on each line.	n Onset and Death
£xaminer		or condition resulting in death) Due to (or as a consequence of):	
	힐	Sequentially list conditions, if any, leading to immediate	
	Examine	cause. Enter Underlying Cause (Disease or injury that unitated Due to (or as a consequence of):	
ruted nd ransit	Ä	events resulting in death) Last Due to (or as a consequence or): d.	
60, e be executed ysician and burial - transit	edical	X UNPENDED 28a per me g912 2-7-11 vt 23a,27,28a-f,per ME G910 12/22/10 TT	
5876C rrificate ling phys			Year
Box 6876 e death certificate the attending phy ed for use as the l	sician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
D. BC: the dest	ᇎ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of the ca	of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death. The law requires that the serificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	d b	1 Yes 2 No 3 Probably 4	Unknown
ords, w requir	Completed	24a. Was an 24b. Were autopsy findin autopsy prior to completion of	
Reco	틹	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2	☐ No
Vital Rec ysician: The his certificate director, page	8	25. Was case referred to medical 26.Place of Death (Check only one) examiner? Uther The second of the control	
n of Vi	은	27. Manner of Death 28a. Date of Injury 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
ion (tending eath.	흹	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	holic
ivisi for At after da Direct	Certification	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route N or Town, State) 2422 Marbourn	
file borning			
To the How within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	Σ	OCME December 9, 2010	ar)
	-	30. Name and address of person who completed cause of death (Item 23a)	
		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Registr			
	-	THAT IS TO BE A LA LANGE OF THE STATE OF THE	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 19,2010 PHYLLIS CONNER December 4:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Broadmead Cockeysville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 07/01/1912 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 98 220-30-1478 Pennsylvania Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits er than "natural", or items 23a or 28a-f show Funeral Director 1 □Yes 2√XNo Maryland | Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13801 York Road 21030 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2XX Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1XXVever Married 2 ☐ Married 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marvin Ellis Conner Josephine Purcell ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara R Conner |411 North Middletown Road, Media, Pennsylvania 19063 Apt D202 Sister-In-Law 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Important: If any injury or once. GreenMount Crematory 12/21/10 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Funer 1 Service 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complic shock, or heart failure. List only one Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 🗷 No Day Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 2 25. Was case referred to medical examiner? Be 26. Place Death (Check only one) Hospital: 1∐Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Division of Vital Records, P.O. Box 68760, signed by t I be detach this certificate funeral After ours after death.

neral Director: A within 24 hours a

Maryland

Saltimore,

Pages 1 and 2

₽

Certification: To Medical

29a. Certifier

State

Registrar

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D., OCKEYSNUE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 18 2010 Physician/ 5:21 December Anne Campbell Sharon Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2 X F Months Days Hours Min 1/08/1950 Mary land Yrs. 217-54-2156 60 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b County Director notified 1 🗌 Yes 2 🏝 No Harrington DE Kent 10f. Zip Code 10g. Citizen of What Country? 10e Street and Numbe "natural", or items 23a or Funeral U.S.A. 19952 4255 Paradise Alley Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 X Married þ altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. 3 Widowed 4 Divorced White Completed Year or Dates al Hygiene. I other than "natur event, the Medical E 16a, Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Patricia Koehler Helen William Matthew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph C. Campbell 4255 Paradise Alley Rd., Harrington, DE 19952 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or 12/21/2010 | Hanover, Maryland 4 🔀 Donation 5 🗆 Other (Specify) Anatany Gifts Registry 21. Signature of Funeral Service License6 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ MOTOSTOHIC COICO disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? Year Yes the hed g Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. **e Funeral Director:** After this certificate has the funeral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29c. License number 29b. Signature

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

sortour

10-09673 William Cousar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 10224
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certific	ate of	Death		R	eg. No.	
Physici Medical Exam	an/ iner		•			2. Date of Dea Month Decembe	th Day Year r 15, 2010	3. Time of Death r 1915 hrs		
		4a. Facility Name (if not institution, giv Maryland General Hospita			41	b. City, Town, or Lo Baltimore	ocation of Death		4c. County o	f Death
Funeral Director		5. Social Security Number 6. S 215-46-5585	,	yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.		th (MM/DD/YYYY)	9. Birthplace (State or Foreign Country) MD
ROY		Usual Residence of Decedent 10a. State 10b. County	100	: City, Town	or Locatio	n I				10d. Inside City Limits
Maryland 28a-f show	tor	MD NA		Balt	imo					1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at ooce.	l Director	10e. Street and Number 3854 Dolfield A	Ave			10f. Zip Code 212.	15		0g. Citizen of Wh	at Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens Department of Health and Mental Hygiens of the than "materiary", or items 23a, or 23a-f sho important: If tiems 73i anaked other than "natural", or items 23a, or 23a-f sho injury or other traumatic event, the Medical Examiner must be notified at occe.	Funeral	11. Marital Status 1 Never Married 2 Married	1 Yes 2X		If Ye	Decedent of Hispa s, specify Cuban, N	Mexican, Puerto		White	- American Indian, Black, , etc. Black
ours afte	d by	3 Widowed 4 Divorced 15. Decedent's Education (Specify o	If Yes, Give Year or Dates: nly highest grade complet	ted) 16a. I	Decedent's	s Usual Occupation			Specify:	
036 ithin 72 hc me. r than "u	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+) na		-	st of working life. D shoremai		ed)	Doc	cs
21215-0036 und be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)				Mother's Name		Maiden Surname)	
212 ould be d Mentz s mark tic even	To Be	Elon Cousar 19a. Informant's Name/Relationship (1	Type, Print)	195	. Mailing					n, State, Zip Code)
i, MD and 2 sho ealth and cem 27 is		Carrie Cousar-1	Mother	3 8	54 I	on (Name of ceme	d Ave,	Balti Date		Md 21215 City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 ABurial 2 Cremation 3 4 Donation 5 Other Specify		cremate WOOC	ory or other	er place) N	12/			lawn, Md
Ball permit Depart Impor		21. Signature of Funeral Service Liger	1 ela		1430	me and Address of Ch F/H 00 Waba;	sh Ave	. Balt	imore.	Md 21215
Physician //		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	ach line.		t enter the	mode of dying, su	ich as cardiac or	respiratory arr	est, shock, or hea	Approximate Interval Between Onset and
xaminer			Hypertensiv		erosc	lerotic	Cardiova	ascular	Disease	Death
	ē	Sequentially list conditions, b. if any, leading to immediate	Due to for as a conseque	nee or):						
10	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseque	nce of):						
executed an and al - transit		d.	AMENDED 23a,	27 por		~011"1 <u>-2</u> 0	1_11 17 +		- .	
8760, inficate be execut ng physician and stree burial - tra	Medic	▼ UNPENDED	AMENDED 23a,		ше				23d. Date of o	delivery
Ox 6876 leath certificat e attending phy	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time	2			Ectopic pregnar	псу	Month Month	Day Year
Box 68 te death certi the attendin	Physician/Medical	1 Yes 2 No 9 Unknown	9 Unknown			er (Specify)				
Division of Vital Records, P.O. Box 68760, in 24 hours after death certificate be hin 24 hours after death. The law requires that the death certificate be the Robours After death. The law seen signed by the attending physici upletely filled in by the fumeral director, page 2 should be detached for use as the burit	þ	Part II. Other significant conditions	contributing to death but	not resulting	in the un	derlying cause give	en in Part I.	_		pute to the cause of death? Probably 4 Unknown
of Vital Records, g. Physiciae: The law requirements certificate has been sineral director, page 2 should be	Completed							24a. Was		Vere autopsy findings available
tal Rec	S								rmed? de	eath? ✔ Yes 2 No
/ital rsiciao: rsiciao: director	B	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ✓ ER/Ou	tpatient		Death (Check o	- /	Residence 6	Other
ing Phy After th funeral	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)		ime of Inj	ury 28c. Injury a	at Work?		now injury occurre	
Division tal or Atteodi rs after death. al Director: //	icatic	2 Accident Investigati	28a Bloop of Injury	- At home, fa	rm street		s 2 No	28f Location (Street and Numbe	r or Rural Route Number, City
Div pital or ours aft	Certification:	3 Suicide 6 Could not determined	De l					or Town, S		or Kurar Kodie Humber, City
Division To the Hospital or Atteod within 24 hours after death. To the Fuoeral Director:	Medical	one) 2 Medical Examiner	an: To the best of my known the basis of examina and manner stated.	owledge, dea tion and/or in	th occurre	d at the time, date n, in my opinion, d	and place, and e	due to the caus the time, date	e(s) and manner and place, and du	as stated. ue to the cause(s)
	Σ	29b. Signature and title of certifier	1.		\	29c. License r		f	29d. Date signe December 1	d (Month, Day, Year)
d	ŀ	30. Name and address of person who		,	u. i),[
	ate	Theodore M. King, Jr., MD	Assistant Medi	icufatura #		11 Penn Stree	et, Baltimore	, MD 21201	<u> </u>	
Regist	trar	31. Date filed (Nantiz Day, Year)	Assesse A	1. 10	Elect					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 19 Day 2 0 1 0 Physician/ Margaret Temple Canning 5:00P M Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MD **Funeral** 8. Date of Birth (Month, Day, Year) 4-9-1914 1 🗆 M 2 🗶 F 96 Days Hours Min 220-07-1383 **Director** Usual Residence of Decedent shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director Carroll MD Westminster 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 St. Luke Circle Funeral 21158 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Force ò þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", Specify: white Completed 3x Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Administrator 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o ပ should be Willard Kent Margaret Temple Kent . Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Langan-daughter 206 Opal Ave., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral 20c. Location - City or Town, State Date ō 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or Baltimore, MD 12-23-10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home Signature of Funeral Service Licensee homices 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final grationy otative Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No ☐ Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No HOSPILE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 20 Dec 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 291 Stones

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, DEC 21

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ rim Year Settu 4:44 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore BonSecours Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 04 - 21 - 5 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 - M 2 - F Hours 220-64-4017 58 Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "...- any injury or other than "...-10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1923 W. 21223 USA Lexington Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian,
Black, White, etc. African 11. Marital Status 1 Never Married 2 Married Completed by Yes 2 K No If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Mrs. Ihrie's 10th Grade Assembler Potato Chip Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Stephany Crim, Sr. Annabelle George 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 Lexington Street Baltimore, MD LaTreace V. Bottoms 1923 W. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Mt. Zion Cem. 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 12-27-10 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. . Signature of Funeral Service Licensee 0 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ anoxic encondepath disease or condition Medical resulting in death) Due to (or as a consequence of) Cardiopal monary **Examiner** TETUS DOST arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No 2 **x** No Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 1)45148 +louse 0 Medical leumber

DHMH 17 Rev 7/2009

State

Registrar

KICARDO OSUPNU 31. Date filed (Month, Day, Year)

2010

Baltimore,

lantand

and address of person who completed cause of death (Item 23a) (Type, Print) Baltimers STRET,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 18 M 20 010 Medical 4a. Facility Name (if not institution, give street and number. Examiner 4b. City To n, or Location of Death 4c. County of Death lunb (0 Lous 8. Date of Birth A (Month, Pay A DC) 5. Social Security Number If Under 24 Hrs. If Under 1 Year **Funeral** . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min 1 M 2 🗆 F 23 Director 28a-f show 10a. State 10b. County 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No 10f. Zip Code o 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 9 1 Never Married 2 Married þ should be filed within 72 hours after and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) own, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 22. Name and Address of Facility
JOSEPH L. RUSS
2222 W. WOLTH f Funeral Service Licens Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Part 1/ Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month ☐ Pregnant at time of death☐ Unknown 2 No Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 Yes 2 No Yes 25. Was c se Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDCA 4 Nursing Home 5 Residence 6 Other (Specify 27. Mann of Death 28c. Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by ☐ Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of cer 29b. Signart 2010

DHMH 17 Rev 7/2009

State Registrar filed (Month, Day,

who completed cause of death (Item 23a) (Type, F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for Amen	d Ite	State of m 3 pe	Marylan r dr.,	d Pepa Cer	tificate of D	lealth and leath	Mental Hyg	jiene _{leg. No.} 2 ()	1.0	10000
			Decedent's Name (First, Mid							2. Date of Deat	th	1-	3. Time of Death
	Physicia Medic		Irvin Crouse							Decembe	r 14, 2	Year 010	6:40 PM M
	Examin		4a. Facility Name (if not instituti	n, give stre	et and numbe	r)		4b. City, Town, or	Location of Death	h	4c. County	of Death	
	K'		Gilchrist Ho	-				Tows			Bal	timor	
	Funeral Director		5. Social Security Number 217–20–5526 — 216 –20–5526	6. Sex	/ 2 □ F	Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr 10		9. Birthp Count Mar	place (State or Foreign try) yland
	nd how at)r	Usual Residence of Decedent 10a. State 10b. Coun	у		10c. City	, Town or Loc	ation				1	0d. Inside City Limits
	laryla 3a-f s iffied	Funeral Director	MD Bal	timor	0		Pol	timore					1 🗆 Yes 2 😾 No
	or 28	ρį	10e. Street and Number	CIHOI	<u>e</u>		Ват	10f. Zip Code			10g. Citizen of V	Vhat Coun	
	with 23a ust b	eral	3717 White Pi	ne Ro	ad #C			21	.220		USA		
	items items er m	Fun	11. Marital Status	12.	Was Deceder Armed Force			/as Decedent of His Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No-		e - Americ	
9	", or	by	1 Never Married 2 🛣 M		1 X Yes 2 If Yes, Give	□ No	1	Yes 2 No		o nican, etc.)	Blac Specify:	k, White, e whi	
3	ours a atural	eted	3 Widowed 4 Divorc	ent's Educa	Year or Dates	43-	47						
Ċ	72 h In "nii Medic	Completed by	(Specify only hig	nest grade d	completed)		(Give k	ent's Usual Occupa ind of work done d ONOT use retired)		<i>ki</i> ng	16b. Kind of Bu	ısiness Inc	dustry
72	filed within 72 hours after death with the Maryland d thygene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at		Elementary/Seconday (0-12 7		College (1-4 o	or 5+)		mixer			asphalt	: pla	nt
פ	e filed within 72 hours after death with the Maryland tha Hygiene. Add other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be c	17. Father's Name (First, Middle	Last)						ne (First, Middle, M	1aiden Surname)	
Sla	ould be fill out and Mental marked imatic ev	ြ	Walter Crous	e					Dora (Gordon			
	sh har 7 is trau		19a. Informant's Name/Relation Helen Crouse/				19b. Mailin 3717	g Address (Street a White Pi	nd Number or Ru Lne Road	ral Route Number, #C Balti	City or Town, S Lmore, N	tate, Zip C ID 2	1220
saitimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic 4 🏋 Donation 5 ☐ Other		noval from Sta			sition (Name of atory or other place	9)	Date	20c. Location -	City or To	wn, State
Balt	permit. Departr Imports any injt		21. Signature of Funeral S. y.	Licensee	HOY	rector	St Ba	Name and Address 1timore.			Baltimo	ore S	treet
	lb sision/		23a. Par 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final	or complicat only one ca	tions that caus ause on each	ine.	. Do not ente	the mode of dying	, such as cardiac	or respiratory arre			Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	a	Due to (or a	s a conseque	ence of:	my	1/1 mm	my a	1 Hays.	4	ins
	Examiner		O . The state of t		·		•	V					:
		Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury	J 0	Due to (bra	s a consequ	งกิดิย บริ่):						
	cuted	хап	that initiated events	c. -	D								
	cian a	ᇤ	resulting in death) Last		Due to (or a	is a consequi	ence oi):						
8	physi the k	edical		d									
0	Sertific Iding Ise as	٤	IF FEMALE: 23b. Was decedent pregnant		If yes, outcom						23d Dat	e of delive	in.
DOX	To the hospital or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live Birtl 4 Pregnan 9 Unknow	t at time of de		Ectopic pregnancy Other (specify)			Mor		Day Year
ָר ר	es that tigned b	by P	Part II. Other significant condi	/	outing to death	but not resu	Iting in the ur	derlying cause give	en in Part I.	11			e cause of death?
ב ב	requir been s	etec	60 (00 (60)	*						1 Ye			·
records,	The law ate has b page 2 s	Sompl								24a. Was ar autops perforn 1 Yes 2	v p	vere autop rior to con eath? Yes	sy findings available npletion of cause of 2 No
	ertifica ector,	Be .	25. Was case referred to medica examiner?		ikalı				ce of Death (Chec		45 110		5 1
> ;	this c	유	1 Yes 2 No	Hosp	1 🗌 Inpa		R/Outpatient		4 L Nursing H	ome 5 - Reside			nospiy
	After After funer	Certificate:	27. Manner of Death 1 Natural 5 ☐ Pend	ng	28a. Date of ir (Month, E		28b. Time of injury	28c. Injury work?		28d. Describe how	w injury occurre	d	
<u> </u>	ctor:	≝	3 Suicide 6 Coul		28e. Place of I	niury - At hon	ne. farm. stree	M 1 🗆 \	res 2 🗆 NO	28f. Location (Str	pet and Numbe	r or Rural i	Route Number
בֿ בֿ	rrs after rrs after ral Dire led in b		4 Homicide deter	nined 2		etc. (Specify)		,,,,	13	City or Town,		- Or Huran	noute Namber,
-	ne nosp	Medical	(Check 2 Medical	Examiner: (On the basis of	examination	and/or investig	ccured at the time, gation, in my opinior eath occurred at the	, death occurred a	at the time, date and	d place, and due	to the cau	se(s) and manner stated.
	Neith Coa		29b. Signature and title of certifi		m			29c. License	number	29	9d. Date signed	(Month, D	ay, Year)
		ŀ	30. Name and address of person	who compl	leted cause of	death (Item 2	23a) (Type, Pr	int)	Cimi	es ST	This	0~	14 2010 M)
	State Registra		31. Date filed (Month, Day, Year)	2010	2. Regis	trar's Signatu	re sear	Sel .					
							150						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Crowley Year 0956 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Conter Wicomico alisbur Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F (Month, Day, Year) Country) 112449572 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director MD Unknown Westover 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Revells MSM 1890 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced Specify: White 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 abore, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ / WOX inare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12590Department of Health ar Important: If item 27 is any injury or other traconce. South Remsen Dang hter Ave. Warpingers Falls, NY I ham 150n 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Wordbine, mD 12-21-10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chowisse N. Woods Funeral Service 21. Signature of Funeral Service Licensee 2700 Edmondson Ave. Boldinare MD 21223 mus)358 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕏 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion death? performed 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗆 Yes 2 11/16 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

10-09777

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

)	0	di-manajamenji	0	2	0	2	3	
---	---	----------------	---	---	---	---	---	--

Jam	es Michael		- For State	tate of Maryla	nd / Depa <i>Cer</i>	artment of <i>rtificate of</i>	Health Death	n and	Menta	al Hy		C U	IŲ	10231
	Physici		Registrar 1. Decedent's Name (First, Midd	ile,Last)				_		2	2. Date of Dea	ath Day Year		e of Death
1	al Exami		James Michael				···				Decembe	er 18, 2010		37 hrs
			4a. Facility Name (if not instituti 1347 Riverside Aven		nber)	4	b. City, To Essex	wn, or L	ocation of	Death		Baltimore (
	Funeral		5. Social Security Number		7. Age (In yrs. la	ast birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of B	irth(MM/DD/YYYY) 9	Birthplace	(State or
	Director	- 1	215-11-1589	1 XM 2 F	39	Yrs.	Months	Days	Hours	Min.	11-22-1		oreign Country)	Maryland
		L	Usual Residence of Decedent											
2	w any		10a. State 10b. County		10c. City,	Town or Locati	_							side City Limits Yes 2 X No
01,1	land f sho	ğ	Maryland	Baltimore			ESSE					10g. Citizen of What		
-	ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 1347 Riverside	Avenue			101. 2.0		21221			US/		
	oth the s 23a c		1. Marital Status		edent Ever in U.			t of Hisp	anic Origi		cify Yes or N	o- 14. Race - A	merican Indi	ian, Black,
	leath v r item	Funeral	1 X Never Married 2 N	Married Armed Fo	rces?	If Yo	es, specify	Cuban,	Mexican,	Puerto F	Rican, etc.)	White, e		
	after o	by F		vorced If Yes, Give Year or Dates:]	Yes 2					Specify:	White	
	hours frant	g	15. Decedent's Education (Sp	100000000000000000000000000000000000000		16a. Deceden during m	t's Usual C ost of work					Tob. Airid of Busin	ess/mausiry	
	36 nin 72 s. than the dical	pe e	Elementary/Secondary (0-12) Conege (1	40(57)		Mech	anic				Auto Indu	ıstry	
	5-0036 iled within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle	e, Last)		<u> </u>		1	8.Mother's	Name (First, Middle	Maiden Surname)		
	121(be fill ental F irked vent, i	Be	James Michael C			140h M-10-	A deles = =	/011		inda	Boss	ımber, City or Town,	State Zin Co	nde)
	MD 21 d 2 should I lith and Mer n 27 is man	٩	19a. Informant's Name/Relation Mr. James M. Colli		ther	1						land 21221	otate, zip oc	,,,,,
			20a. Method of Disposition		20b.	Place of Dispos	ition (Nam				Date	20c. Location - Ci	ty or Town, S	State
	Baltimore, permit. Pages l at Department of He Important: If ite		1 X Burial 2 Crematic			crematory or oth rkwood Ce		,		12-22	2-2010	Baltimore.	Maryla	and
	altin nit. P partme portan		4 Donation 5 Other 3 21. Signa e Funeral Service		1	22. N	lame and A	Address	of Facility			Harford Road		
	E P P E		Charles 1	Mem	11_		nard J					more, MD 212		oximate Interval
-	Physician /Medical		23a. Part I. Enter the e, c failure. List only one caus	or complications that c e on each line.	d the death	n. Do not enter ti	ne mode of	ayıng, s	such as ca	ralac or	respiratory a	rrest, shock, of fleart		veen Onset and Death
-	Examiner		Immediate Cause (Final diseas or condition resulting in death)		consequence of						_		_	
			Sequentially list conditions,	b.	consequence	217.								
		Je l	if any, leading to immediate cause. Enter Underlying Caus	e	consequence o	of):								
		Examiner	(Disease or injury that initiated events resulting in death) Last	C. Due to /or co c	consequence of	of):								
	0, be executed sician and burial - transit			d										
), be exe sician a urial -	dical	X UNPENDED	AMENDED										
	Records, P.O. Box 68760 The law requires that the death certificate be cate has been signed by the attending physipage 2 should be detached for use as the bu	ľ.	IF FEMALE: 23b. Was decedent pregnant in		outcome of preg irth		tal death	3	Ectopic	pregnar	псу	23d. Date of de Month	Day	Year
	th cert ttendir r use a	sician/M	past 12 months?		ant at time of de		her (Spec	ify)						
	Box he death of the attent hed for us	Phys	Part II. Other significant cond	9 Onkik		resulting in the c	ınderivina	cause di	iven in Par	rt I.	23e. Did	tobacco use contribu	te to the cau	use of death?
	ing Vital Records, P.O. Bing Physician: The law requires that the defent this certificate has been signed by the tuneral director, page 2 should be detached	þ	rath. Other significant conc	inora contributing to	, death but hot	Cooling III are					1 □ Y	es 2 🗹 No 3	Probably 4	4 Unknown
	ds, equire een sig ould bo	Completed						-			24a. Wa			indings available ion of cause of
	COT e law r e has b ge 2 sh	葿									per	formed? dea	ath? Yes	2 \ \ No
			25. Was case referred to media	cal			2	6.Place	of Death (Check o				
	ion of Vital Itending Physician: leath. tor: After this certify the funeral director,	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2] ER/Outpatient	3 D	OA (Other ₄	Nursing	g Home 5	Residence 6	Other: Scene	e
	ion of tending Pheath.	i i	27. Manner of Death 1 X Natural 5 Pe		of Injury , Day,Year)	28b. Time of	Injury 2		y at Work′ 'es 2		28d. Describ	e how injury occurred		
	sion ttend death. ctor:	atic		nding restigation		farm_atro	et factory				28f Location	(Street and Number	or Rural Rou	ite Number. City
	Division tal or Attendii rs after death.	Certification:	de	ould not be termined (Specify)	e of injury - At r	nome, farm, stre	et, lactory,	Onice Di	ulialig, ett		or Town		0	,
	Divi	ဦ	4 Homicide 29a. Certifier 1 Certifying	Physician: To the her	st of my knowled	dge, death occu	rred at the	time, da	te and pla	ce, and	due to the ca	use(s) and manner a	s stated.	
	Division To the Hospital or Attendit within 24 hours after death. To the Funeral Directors. completely filled in by the fi	Medical	(Check only one) 2 Medical Ex	kaminer:On the basis and manners	of examination	and/or investiga	ition, in my	opinion,	death oc	curred a	t the time, da	te and place, and due	to the cause	
	- F & F 8	¥	29b. Signature and title of cert				290		number			29d. Date signed	•	y, Year)
•	_		Mayante Dr	elkell				O.C.N	vi.∟. ————			December 1	ə, 2010 	
			30. Name an address of pers				enn Str	eet Ra	altimore	, MD :	21201			
		tate	Margarita Korell MD 31. Date filed (Month, Day, Yea		egistrar's Signa	ture a								
	Regi			DOSO DO	sense &	1. par	Kal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depart	tment of Health and M ficate of Death		2010	10231
			Registrar 1. Decedent's Name (First, Middle, Last)	neate or Beatin	2. Date of Death	j. No.	3. Time of Death
	Physicia		Shoke-Hwee Khaw Cua		December	Pay 2010	7:35 A M
	Medic			4b. City, Town, or Location of Death	Бесемьет	4c, County of Death	7.33 A
	Examin	er	Manor Care - Potomac	Potomac		,	
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montg	omery lace (State or Foreign
	Funeral Director				(Month, Day, Ye November 29	9, 1926 Burm	m)
			Usual Residence of Decedent		November 2	7, 1920 Bulm	a
	and shov	o	10a. State 10b. County 10c. City, Town or Locat	tion		1	0d. Inside City Limits
	faryli 3a-f tifiec	ect	Maryland Montgomery	Bethesda			1 ☐ Yes 2 🛣 No
	or 2	ᅙ	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Coun	try?
	with 23a 1st b	Funeral Director	7525 Cayuga Avenue	20817		United Sta	tes
	eath tems er mu	Ę.	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	s Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - America	
ဖွ	or it	by F	1 Never Married 2 Married 1 Never Married 1 Never Married 2 Married 1 Never 1	es, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, e	etc.
8	rsaft rral", Exa	ed		Yes 2 XNo Specify:		Specify: Asia:	n
9	hou natu dical	Completed	15. Decedent's Education 16a, Deceden	nt's Usual Occupation	16	b. Kind of Business Inc	lustry
2	in 72 e. nan "	Щ	(Give kind Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	d of work done during most of workir NOT use retired)	ng		
2	with gien er th		5+	Homemaker		Own Hom	e
p	be filed within 72 hours after death with the Maryland kend litygiene. Kend thygiene than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Mai	den Sumame)	
<u>a</u>	ould be filed within 72 hours after death with the Maryland id Mental Hygiene. In Mental Hygiene. Matted other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	J.	Boon-Teng Khaw	Kyin Su	Tan		
a٦	houl and h is m		19a. Informant's Name/Relationship (Type, Print)	Address (Street and Number or Rura	l Route Number, Ci	ty or Town, State, Zip C	ode)
Σ	d 2 salth alth 27		Athene Khaw Cua/Daughter 127 Tr	illium Hill, Mon	tpelier,	Vermont 05	602
Baltimore, Maryland 21215-0036	age 1 and 2 should be ant of Health and Menta t; If item 27 is marked or other traumatic e		20a Method of Disposition 20b Place of Disposition	ion (Name of		lc. Location - City or To	
Ë	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematorium	m Tnc Decem		ethesda, Ma	ryland
Ħ	permit. Page Department of Important; If any injury or once.		21. Signature of Funeral Service Accessed	Name and Address of Facility ert A Pumphrey	7 1	Bethe	sda-
ñ	Dep lmp any		Harav / Charles M01530 755	ert A. Pumphrey 7 Wisconsin Aven	Funeral F	lome, Chevy	Chase, Inc
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the				Approximate
	NE		shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Interval Between Onset and Death
	Physician/ Medical		disease or condition Metastatic Lung (Cancer		1	Month
	Examiner		Due to (or as a consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	ed isit	盲	cause. Enter Underlying Cause (Disease or minury)				
	ecut and I-trar	Examiner	that initiated events c				
_	oe ex ician buria	dical I					
09/	phys the I	gi	d	·			
89	ertific ding se as	Physician/Me	IF FEMALE: 23b. Was decedent program 23c. If yes, outcome of pregnancy			COL Date of Julius	
Вох	ath o	iai	23b. Was decedent pregnant in the past 12 months? 1	Ectopic pregnancy Other (specify)		23d. Date of delive	ry Day Year
ň	e dea the a	ysic	1 Yes 2 A No 4 Pregnant at time of death 5 1 C 9 Unknown	other (apacity)			,
O.	at th d by letac		Part II. Other significant conditions contributing to death but not resulting in the und-	lerlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
J.	es th signe l be c	l by			1 X Vas	2 □ No 3 □ Prob	ably 4 🗆 Hoknown
ğ	equir een :	etec		4			
ပ္ပ	law r nasb	Completed			24a. Was an autopsy	prior to cor	sy findings available npletion of cause of
æ	The cate h	Š			performe 1 Yes 2	d? death? No 1 ☐ Yes	2 🗆 No
g	sian: ertific ctor,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check			
>	hysic his o	은	1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing Hor	me 5 🗆 Residend	e 6 Other (Specify)	
Division of Vital Records,	ng P fter t inera	ite:	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how		
0	endii eath. or: Ai he fu	lice	2 LAccident Investigation	M 1 Yes 2 No			
<u> S</u>	r Att	Certificate:	3	r, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural	Route Number,
á	talo irsaf al Di						
	losbi t hou uner ed fil	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occ (Check 2 Medical Examiner: On the basis of examination and/or investiga				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, dea				
	70 Vitt		29b. Signature and title of certifier	29c, License number		. Date signed (Month, E	
			I Thomas Masterson un	D50534	I	December 17	, 2010
)			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin				
J			Thomas Masterson, M.D. 1313 Dolley Ma	adison Blvd. #302	2, McLean	, Virginia	22101
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registra	ar	DEC 21 2010 Peners J. Janes.				

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death M12/19/2010 Physician/ LaVelle Muriel DuDonis 1:46 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hanover Howard 6116 Adcock Lane Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birtl **Funeral** Months Days Hours 1 □ M 2 🔀 F 1272871931 Maryland 78 Director 217-26**-**8819 Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director Howard Hanover 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 6116 Adcock Lane 21076 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: "natural" Completed 3 X Widowed 4 ☐ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 0 <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ Page 1 and 2 should be Robert R. Santmyer Muriel Lahmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6116 Adcock Lane, Hanover, Maryland 21076 Jacqueline L. Patel / Daug. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland Meadowridge Mem. Pk.: 12/22/2010 Donation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. igriatu e of Funeral Service Licen 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyir shock, or heart failure. List only one cause on each line. Approximate erval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 M 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 2 🗌 No 1 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: Certificate: To 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how Injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation To the Funeral Director, completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 2010 12/20

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

lane, Suite 201, Catonsville, Maryland 21228

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

724 Maiden Choice

Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 1<u>8,</u> Physician/ 2010 December 9:54 P M Dolinka Ann V. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casev House 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Year) 932 1 □ M 2 🕱 F Months Days Hours May 26, Pennsylvania Director 78 168-26-2812 Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5804 Rolling Drive 20855 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) ပ္ Benjamin Olena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert F. Dolinka/husband 5804 Rolling Drive Derwood, Maryland 20855 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/21/2010 Woodbine, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Going Home Cremation Service P.O. Box 784 ianto M00957 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Our to for an a nonexcurrence off If any leading to immediate cause. Enter Underlying Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 X No 9 Unknown cate has been signed by page 2 should be detach Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Systemic Lupus Erythematous 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of Frequent Pneumonia After this certificate has autopsy death? performed? 1 Yes 2 No 1 ☐ Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending Pl 124 hours after death.
 Funeral Director: After th 28c. Injury at 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No injury X Natural 5 Pending Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the pasis or examination and/or investigation, in my opinion, scalar account and out to the cause(s) and manner as stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060634 December 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, M.D. 6001 Muncaster Mill Road Rockville, Maryland 20855

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 40234

		registial	tem zoa p	Cei	tificate of	Death				g. No.	~	
Physici Nedical Exam		1. Decedent's Name (First, Midd Gary Ant)		Dix					Date of Death Month Day Year December 16, 2010			me of Death 503 hrs
		4a. Facility Name (if not institution			1	4b. City, Town, or	Location of					
		2947 Freeway				Landsdowr	1			Baltimore	∋ County	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 Year Months Day			8. Date of Birtl	h (MM/DD/YYYY)	9. Birthplace Foreign	e (State or
Director		215-72-0071	1 M 2 F	5	2 Yrs	i. Worth's Day	01/18/1958 Country) Mary 1					Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Locat	ion					10d	Inside City Limits
E			imore		nsdowne							Yes 2 X No
Maryland 28a-f show 1 at once.	cto	10e. Street and Number	IIIOLE	Па	115GOWI16	10f. Zip Code			10	g. Citizen of Wha		
ith the Ma 23a or 28 notified	Director	2947 Freeway				21227					,	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers (tem 77 is marked other than "natural", or items 23a or 28a-f sho traumatte event, the Medical Examiner must be notified at once.		11. Marital Status		cedent Ever in U.		s Decedent of Hi			ify Yes or No-		- American In	idian, Black,
death or iter must	Funeral	1 Never Married 2 M	larried Armed F	orces?	If Y	es, specify Cuba	n, Mexican,	Puerto Ri	can, etc.)	White,	, etc.	
	by F		vorced If Yes, Give Ye or Dates:		1 🗆	Yes 2 X No					White	
hours fnatu Exen		 Decedent's Education (Spe Elementary/Secondary (0-12) 		1-4 or 5+)		nt's Usual Occupa ost of working life				16b. Kind of Bus	siness/Industr	У
36 hin 72 e. than edical	Completed	Elementally/Secondary (0-12)		4	F	Engineer				Defe	onco	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Con	17. Father's Name (First, Middle		1		ingrineer	18.Mother's	s Name (F	irst, Middle, M	laiden Surname)		
215 be fill ntal H rked ent, t	Be	Edward Jo	ohn I	Dix			Naon	ni	Dea	n I	Ramsey	
21 hould nd Me is ma	၉	19a. Informant's Name/Relations			2	g Address (Stre	et and Numi	ber or Rur	al Route Num	ber, City or Town	ı, State, Zip C	ode)
MD and 2 sho alth and 27 is		Holly Christin 20a. Method of Disposition	na Dix / I			ASCOT I						01-1-
P L R		1 Burial 2 Cremation	n 3 Removal f		crematory or ot		metery,		Date	20c. Location -	City or Lown,	State
Baltimore permit. Pages 1 Department of H Important: If i		4 X Donation 5 Other S		Ana		ts Regist				Hanover		
Bait permit. Depart Import	S .	21. Signature of Funeral Service	ricensee			lame and Addres		Alld	tomy G	ifts Rec	gistry	
Physician		23a. Part I. Enter the disease of		caused the death.	Do not enter t	22 Conne he mode of dying	, such as ca	ardiac or re	Ste	P,Hanov st, shock, or hea	<u>⊅er, MI</u> irt Apr	D 21076 proximate Interval
/Medical	6: VI	failure. List only one cause	1-4	unshot Wour	nd						Bet	tween Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)		a consequence of								
		Sequentially list conditions,	b									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause		a consequence of	r):							
ة. م √	xau	(Disease or injury that initiated events resulting in death) Last		a consequence of	f):							-2
executed an and al - transit		- Luisevaes	d									
O, s be s be	/Medical	UNPENDED	AMENDED							1		
,= ,-		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	he 23c. If yes,	outcome of pregi birth		tal death 3	Ectopic	pregnanc	у	23d. Date of o	delivery Day	Year
Box 68': death certifi the attending	sicie		4 Preg	nant at time of de		her (Specify)				1		
the de	Physiciar	Part II. Other significant condit	9 Onkr		esulting in the I	Inderlying cause	given in Par	rt I	T23e Did tol	pacco use contrit	bute to the ca	use of death?
ords, P.O. It requires that the as been signed by a should be detach.	þ		morro contributing	io dodan bat not re	southing in the t	andonying cadso	givoiriiri ai		11	2 ✓ No 3	_	
ds, equire een sig	Completed								24a. Was a			findings available
COF law r has b	mp(· · · · · · · · · · · · · · · · · · ·							autops perform		rior to comple eath?	etion of cause of
tal Rec		25. Was case referred to medica	ni I			26 Plac	e of Death (Chock on	1 Yes 2	2 No 1	✓ Yes	2 No
of Vital Records, ng Physician: The law require ufter this certificate has been si meral director, page 2 should b	o Be	examiner?	Hospital: 1	Inpatient 2	ER/Outpatient		Othor -			Residence 6	Other: Scer	10
n of \ding Phy. After tl funeral	Ė	27. Manner of Death	28a. Date		28b. Time of I	njury 28c. Inju	iry at Work?	? 28	3d. Describe h	ow injury occurre	_	
ion tendin eath. tor: A	cation	1 Natural 5 Pend 2 Accident Inves	ding Tob To	6/2010	1453 hrs	1	Yes 2	No St	ubject shot	self		
Division tal or Attendi rs after death al Director: /	ertific	3 Suicide 6 Coul	ld not be 28e. Pla	ce of Injury - At ho	ome, farm, stree	et, factory, office	building, etc	c. 28	Bf. Location (S or Town, St		r or Rural Ro	oute Number, City
file ou pi	Cerl	4 Homicide dete	rmined (Specify) Townhouse	9			29	47 Freeway,	, Landsdown, N	ND	
To the How within 24 h	ical	(Check only Certifying Pi	hysician: To the be miner:On the basis									se(s)
To t To t	Medical	29b. Signature and title of certifie	and manner			29c. Licen:				29d. Date signe		
		6/11/	1 5	4			M.E.			December 1		-,, ,
- K	1	30. Name and address of person	who completed cau	ise of death (Itism	23a)							
Θ	25 15		Assistant Medi			n Street, Bal	timore, M	/ID 2120)1			
	63.60	31. Date filed (Month, Day, Year)	32. R	egistrar's Signatu	ire							
Regis	trar	DEC 21 2010	Lensen	B. B.	arrive							
DHMH 17 Rev 1/2	2001		1-3.	1	ORIGINA	L					OCME	

State
Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #26 PER PHY G910 112/21/10 JH

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ I5, 2010 December Mary A. Davies 04:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1524 H. Sharen Drive Salisbury Wicomico Co. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 M 2 XF Days Hours 71 0910611939 047-32-0333 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Howard Ellicott City 1 Tes 2 No 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3409 Font Hill Drive 21042 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 þ 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental F Important; If item 27 is marked o any injury or other traumatic eve once. ပ္ Edward Leary Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Cathleen Caccamisi/Daughter 3409 Font Hill Road Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Atlantic Crematory 12/20/2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral S 22. Name and Address of Facility Singleton Funeral & CremationM01121 Services PA; 2nd Ave SW, Glen Burnie, 23a. Part 1. Enter the disease, or combline from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Sevile Rmentia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Directo for as a consequence of the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Hypurlipidenia 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 2 🗆 No Yes 2 🖾 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) DAUGHTER'S Hospital 1 ☐ Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Thesidence 6 Nother (Specify) RESTDENCE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No. hours after death Investigation M the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 h (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29c. License number 2010 Physician 729 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.C. Patronicz 1820 Tweet Bay Drive , D.O. Suite 101

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 40237 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Belvia Geneva 2010 8:01PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 33 Chestnut Hill Avenue Severna Park Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X Months Hours Min Month Day, 76 Yrs **Director** 229-44-2884 TN Usual Residence of Decedent 28a-f shov I Hygiene. . other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 ☐ Yes 2X No Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 91 Summer Hill Park 21032 U.S.A within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc \$ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Communications Clerk State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Timothy Hampton Anna Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh. Department of Health ar Important: If item 27 is Mr. Roger D. Dean / Son 33 Chestnut Hill Avenue Severna Park, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury or Hillcrest Mem. Garden 12/21/2010 Annapolis, MD 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service Licensee Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Oper and Jath shock, or heart failure. List only one cause on each line Immediate Cause (Final nysician/ to rune disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Que to for as a nonsequence on sician and burial-transit Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): e attending physician and for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mont Month rate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes lesidenc 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 📝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

Madeson

ted cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene [] 40238 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DELEMBER 13 2010 12.34M Edgar A. Doneski Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death GIEN BUIZNIE BALTIMORE BLACKINGTON MEDICAL CENTRE GUNB ASILVINA CA Social Security Number **Funeral** Birthplace (State or Foreign Country) 1**X** M 2 □ F Months **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Glen Burnie 1 Yes 2 No Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1024 Glenvilla Dr 21061 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MD Ship Building Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Adam John Doneski Emma Helen McDaniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolee Floyd Doneski wife 1024 Glenvilla Dr, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Glen Haven Cemetery Dec 15, 2010 Glen Burnie, MD 21. Sign Funeral Service License Name and Address of Facility Fink Funeral Home, P.A. Gregora 426 Crain Hwy S, Glen Burnie, MD 21061 Part 1. Enter the diseashock, or heart failure plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Immediate Cause (Fina Onset and Death Physician/ LINEUM ONICE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of). sician and burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending work? 2 Accident
3 Suicide Investigation 2 🗆 No To the Hospital or Atte within 24 hours after de To the Funeral Director completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check The Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat cand title of certifier me and address of person who co rpleted cause of death (Item 23a) (Type, Print) Glen Burnie MD 20161 10. Date filed (Month, Day, Year, State 32. Registrar's Signati Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

J.

	101. Zip Code	iog. c	Juzen or v	vnat Country:
	20886	Un	ited	States
. W	as Decedent of Hispanic Origin? (Specify Yes or N	0-		e - American Indian

Certificate of Death

Yrs.

4b. City, Town, or Location of Death

Montgomery Village

1 ☐ Yes 2 🔯 No

Gaithersburg

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Homemaker Own Home

Dwight Hunt 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9920 Walker House Road, #1, Montgomery Village, MD 20886

Scott Dikkers / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) December 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 21, 2010 4 ☐ Donation 5 ☐ Other (Specify)

M01305

Bethesda, Maryland

20c. Location - City or Town, State

Reg. No.

2010

Montgomery

Illinois

4c. County of Death

 A^{M}

1:25

9. Birthplace (State or Foreign

10d Inside City Limits

10 Minutes

1 ☐ Yes 2 No

2. Date of Death

December

December 5, 1931

21. Signature of Funeral Servi - Licensee mayetter month 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ROBERT A. Fumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death

18. Mother's Name (First, Middle, Maiden Surname)

Margaret McMillen

Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 🗓 No

IF FEMALE:

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): Coronary Artery Disease

Myocardial Infarction

Years

Due to for as a consequence of

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Year Month Day

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

Urinary Tract Infection, Dementia

Hospital:

24a. Was an autopsy 2 X No 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

25. Was case referre examiner?	d to medical	L
1 Yes 2 X N	lo	
27. Manner of Death		
1 🔀 Natural	5 Pending	
2 Accident	investigation	ì

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 💆 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

2 Accident

4 Homicide

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman Tuli, M.D. 10810 Darnestown Road, Suite 202, Gaithersburg, Maryland 20878

Registrar

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

Box 68760,

Physician

Examiner

/Medical

physician and s the burial-transit

Examine

Physician/Medical

δ

Completed

Be

Certification: To

Medical

death.

within 2.

Director:

that the death certificate be executed P.0. Division of Vital Records, the Hospital or Attending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:30р.м Ralph Elmer Evler 2010 Medical December 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northhampton Manor Frederick Frederick Year If Under 24 Hrs. 5. Social Security Numbe . Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days Director MD 220-30-7663 93 show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 No PA Adams Fairfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 17320 11 Pecan Trail USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify "natural" 3 Widowed 4 ☐ Divorced Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the <u>Organ repairman/builder</u> repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dora Elizabeth Miller <u> Allen C. Eyler</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 11 Pecan Trail, Fairfield, PA 17320 Jean Eyler-niece Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Thurmont, MD Blue Ridge Cemetery 12/23/2010 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications the c used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or eagl line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ 200 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No s been signed by the should be detached g Unknown 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe this certificate has death? Yes 2 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month DOO 18703 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 310 S. Seton Ave., Emmitsburg, MD 21727 Alan Carroll, M.D.

State Registrar 31. Date filed (Month, Day, Year)

R 05A M· $\mathcal{E}UU150N$ Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	e Type or Print State of Man						_		_	
		•	For State Registrar	State of Ivial	ylariu /		tificate of		and i	nemarry	Reg. No	71111	40241
Ph	ysicia	ın/	1. Decedent's Name (First, Middle, L		13.3.4					2. Date of De	eath	av Year	3. Time of Death
	Medic xamin	cal	Rosa 4a. Facility Name (if not institution, gi		llis	on	4b. City, Town,	or Location	of Death	Month 2	Di Di	2010 County of Dear	4:40 AM
,e	Adillili	i Ci	Good Samari	tun Hospital	′			TIMO	RE		40	NA	
	neral ector			1 N OVIV	n yrs. last b 7 ()	irthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bi	rth ay, Year)	g. Bir Co	thplace (State or Foreign untry) VA
-		_	Usual Residence of Decedent 10a, State 10b. County		Oc. City, To	wn or Loc	eation			11.0.	1 40		
larylan	ba-r sn Lified a	ecto	MD NA		Balt								10d. Inside City Limits X
be filed within 72 hours after death with the Maryland ental Hygiene.	rar, or items 23a or 26a-r snow Examiner must be notified at	Funeral Director	10e. Street and Number	1. A			10f. Zip Code	2.4			10g. Ci	itizen of What Co	ountry?
ath wit	r must	nner	1329 Dartmout	12. Was Decedent Ever	r in U.S	13 V	212.		rigin? (Spe	ecify Yes or No	- 1	USA 14. Race - Ame	riogn Indian
fter de	amine	þ	1 Never Married 2 XMarried	Armed Forces?			Vas Decedent of I Yes, specify Cub			Rican, etc.)		Black, White	e, etc. African
ours a	aturar cal Ex	eted	3 Widowed 4 Divorced 15. Decedent's	Year or Dates.	16		ent's Usual Occu		·.		10h k	Specify: Ame	
in 72 t e.	Medi	Completed	(Specify only highest Elementary/Seconday (0-12)	Collected) Collected (1-4 or 5+)		(Give k life. DC	ind of work done O NOT use retired	during mos)		ing	1	Kind of Business Lovin	•
ed with Hygien	oner o	اما	6th Grade 17. Father's Name (First, Middle, Last		L	Оау	Care P	т		e (First, Middle	lDay	Care	
d be file	tic eve	힏	Johnny	Brandon					ievi	, ,	, iviaideri	Thornt	on
should and h	rauma		19a. Informant's Name/Relationship				g Address (Street						*
and 2 Health	tem 2		Terrance E1] 20a. Method of Disposition				Dartmo	outh !		nue Ba Date		more, Mocation - City or	ID 21234
Page 1	iry or c		1XXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State	Mt.	tery crem Zio	n Cem .	ce)		23-10		nsdown	
bermit.	Important: If them 2/18 marked other than "natural", any injury or other traumatic event, the Medical Exalonce.		21. Signature of Funeral Service Lice	psee)			Name and Addre						me P.A.
00	- 10 0	Н	23a Part 1. Enter the disease, or co	mplications that caused the	e death. Do							timore	, MD 21217
Physic	cian	1 9	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.			,	3.		, ,	ŕ		Interval Between Onset and Death
Me Exan	dical niner		resulting in death)	a. Due to (or as a co	onsequence	e of):							
		ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a co	onsequence	e of):						_	
cuted	ransit	Examiner	cause. Enter Underlying Cause (Disease or imjury that initiated events	C									
be exe	for use as the burial-transit		resulting in death) Last	Due to (or as a co	onsequence	a ot):							
ificate	as the	Physician/Medical	IF FEMALE:	a .									
ith cert	or use	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p			Ectopic pregnan	су				23d. Date of del	ivery Day Year
the dea	ached f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tin 9 ☐ Unknown	ne or death	1 5 L	Other (specify) _					Wiener	Day Tour
s that	be deta	ρ	Part II. Other significant conditions	_		g in the ur	nderlying cause g	iven in Part	1.				the cause of death?
require been s	plnode	eted	Acute Myelo	in contemio						1 L			obably 4 Unknown
he law te has	age 2 s	Completed								auto perfe		prior to death?	completion of cause of
cian: T	ector, p	Be	25. Was case referred to medical examiner?	Hamileli				lace of Dea	ath (Check		2 L N	o I res	2 LT NO
Physic r this c	eral dire	은 ::	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of injury		Outpatient	3 DOA Oth	4 <u>∟</u> N		me 5 Resi		Other (Spec	f(y)
ending sath. or: Afte	he fune	ficate	1 Natural 5 Pending 2 Accident Investigati	(Month, Day, Ye		injury	wor		. 1	zou. Describe	now mjur	y occurred	
or Atte	in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			farm, stre	et, factory, office			28f. Location (City or Tox			al Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	d filled	Medical	29a. Certifier 1 Certifying Ph	nysician: To the best of my	knowledge	e, death o	ccured at the time	e, date and	place, an	d due to the ca	ause(s) ar	nd manner as sta	ted,
the Ho hin 24 the Fu	mplete		only one) 3 Certifying Nu	miner: On the basis of examure Practioner: To the best	ination and t of my know	l/or investi wledge, d	eath occurred at the	ne time, date	ccurred at e and plac	the time, date e, and due to the	ne cause(s	s) and manner as	stated.
고 <u>≨</u> 5	8 8		29b. Signature and title of certifier	MD			29c. Licens	S 00	0			te signed (Month 2	
			30. Name and address of person who	completed cause of death	(Item 23a)	(Type, Pr				Boiltimo		<u> </u>	
Re	Stat egistra	e	31. Date filed (Month, Day, Year) DEC 21 2010	32. Registrar's									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)

MHN GH NET 2. Date of Death 3. Time of Death EDWARDS Physician/ 8:10P Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner SECOUNT HOJATTAL MD BALTIMORE if Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F 217-20-0050 83 MD Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1522 W. Fayette Street Apt.A 21223 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2XXNo Black, White, etc.African 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: American 3 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade NA Domestic Home maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked t any injury or other traumatic eve once. 2 Mildred Bennett 19a. Informant's Name/Relationship (Type, Print) Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 1522 W. Fayette Street Apt."A" Baltimore Shanell Walker-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) XXBurial 2 Cremation 3 Removal from State Loudon Park 12-27-10 Baltimore, MD 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service License 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest area n each ling. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final Orset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day been signed by the s should be detached i Part II. Other significant conditions contributing to death g in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No 24a, Was an page 2 autopsy performed Yes 2 this certificate has within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) CCC/8m completed cause of death (Item 23a) (Type, Print) 2000 W BALTIMORE ST, BALTIMORE MD 2/223 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eginton 38 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** niversity Baltimore Mary land Medical Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New Jersey 1 **X**M 2 □ F Days Min Feb. 28 Director 141-40-9819 Usual Residence of Decedent 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits **Funeral Director** 1 🗌 Yes 2 💢 No **Baltimore** Glen Arm Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21057 U.S.A 6 Manor Springs Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Axa Eguitable Actuary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harold James Eginton Evelvn Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Arm, Maryland Lynn Eginton 6 Manor Springs Court 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 12-17-2010 Towson Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, au 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph_sician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🔀 No Other: မ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie AU4176435 P18170 ecember 14 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Baltimore, MD 21201 22 S. Greene St. rate 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

10-09569	9
Darryl B	Enote

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Darryl B. Foote		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Reg. No.										
Physician	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year										
Medical Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										
		826 West North Avenue Baltimore N/A										
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Stat Country) 4. Security Number 1. Months Days Hours Min.	e or Foreign									
		Usual Residence of Decedent	リ									
ow any		Tod. State	City Limits 2 No									
aryland	Director											
215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. **Red mither than "aatural", ur items 23a or 28a-f sho rent, the Medical Examiner must be notified at once.	2	5609 Midwood Ave 21212 USA										
ath witl	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, E White, etc.	Black,									
after de) 교	3 Wildowed 4 Divorced If Yes Give Year 1 Yes 2 No specify Specify Specify										
hours a												
5-0036 led within 72 hours a Hygiene in infore than "natura the Medical Exami	Completed	Machine Operator Machiner	4									
215-0036 be filed within 7 mtal Hygiene. rked ather than ent, the Medical												
D 2121 should be fi and Mental I 7 is marked natic event,	o Be		- 1									
e, MD 21 I and 2 should Health and Me fitem 27 is ma	ı	Mariene Foote-White 5609 Midwood Ave, Battimore, La 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State										
MOFE, Pages I an nent of He ant: If ite	١	1 Surial 2 Cremation 3 Removal from State crematory or other place)	MD									
Baltimore, permit. Pages 1 a Department of He Impartant: If ite injury or other in	ų.	21 Significant Funeral Service Icensee 22. Name and Address of Facility	tore									
	4	X sun y. Noul se Head Liberty Height Ave, Balto MD	21207 ate Interval									
Physician /Medical	-1	failure. List only one cause on each line. Alashal and Nanashia Intervious in a Discontinuous Control of the C	Onset and eath									
²xaminer		or condition resulting in death) ALCONOL and Natcolle Intoxication Due to (or as a consequence of):										
	اةِ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										
	Examiner	C. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
executed an and al - transit	dical E	d. X UNPENDED AMENDED 23a,27,28a-f per me g912 2-23-11 vt										
ciar rial	Jed -	X UNPENDED AMENDED 23a, 27, 28a-1 per me g912 2-23-11 VL IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery										
x 687 h certifica tending pl use as the	any	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Owner (Specific)	Year									
Box 6 e death cert the attendii	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown										
Division of Vital Records, P.O. Box 68760 and or Attending Physician: The law requires that the death certificate be an area fear death. The law requires that the death certificate by an area for the funeral director, page 2 should be detached for use as the butter of the former of the fear o	2	1 Yes 2 No 3 Probably 4 ✔										
ords, w require is been si should b	Completed	24a. Was an 24b. Were autopsy finding autopsy prior to completion of										
Reco The law cate has	E C		No									
Vital Recc ysician: The lav his certificate ha director, page 2	Be	25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital:	3									
ding Phys	٩	1 ✓ Yes 2 No										
sion trendin death. ctor: A y the fu	jatio jatio	1 Natural 5 Pending Investigation Fd 12-12-10 Fd 4:53pm 1 Yes 2 No unknown	1									
DIVISION pital or Attent ours after death teral Director: filled in by the	Certification:	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 1 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 1 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 1 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 1 Suicide 6 X Could not be determined 29e. Place of Injury - At home, farm, street, factory, office building, etc. 1 Suicide 8 X Could not be determined 29e. Place of Injury - At home, farm, street, factory, office building, etc. 1 Suicide 8 X Could not be determined 29e. Place of Injury - At home, farm, street, factory, office building, etc. 1 Suicide 8 X Could not be determined 29e. Place of Injury - At home, farm, street, factory, office building, etc. 1 Suicide 8 X Could not be determined 29e. Place 29e. Place 30e.										
Tot with Totl com	Medical		ar)									
		Theodor M. Kish Thymad: O.C.M.E. OGME December 13, 2010										
	Ī	30. Name and address of person who completed cause of death (Item 23a) Thepdore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimpre, MD 21201										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lam Farooq		I- For State	St	ate o	f Maryla		artment of <i>rtificate of</i>			Menta	al Hyg	giene	Reg. N	2 (4.3.3.00pm	402	45	
Physicia	_	1. Decedent's Name (First, Middle,Last)								- 1	. Date of D Month	eath	v Yea	ar .	3. Time of Death			
≕sal Examir		Ghulam		Farooq						3, 2010		2001 hrs						
		4a. Facility Name (if not in University of Mar					1	4b. City, Town, or Location of Death Baltimore					4c. County of					
F	4	5. Social Security Number		6. Sex	T T G G I T G	7. Age (In yrs.	last birthday)	If Under		If Under	24Hrs.	8. Date of	Birth(N	M/DD/YYY	9. Birt	hplace (State or		
Funeral Director		062-92-403			2 F	46		Months		Hours	Min.	10	06	64	Foreigi Cou	p'akista:	n	
	1	Usual Residence of Dece		M IV	2F	40) 113	.]		l		10_	00	04_		rakista.	11	
any		10a. State 10b. C				10c. City	, Town or Locat	ion								10d. Inside City Li		
B	٦	MD B	al	timo	ore		Win	dsor	Mi	11						1 Yes 2 X	No	
1aryla 28a-f	Director	10e. Street and Number								10g. (Citizen of W	hat Country?						
ith the Maryland 23a or 28a-f show notified at once.		1712 Chesterton Road								244					Pakistan			
n with	era	11. Marital Status 1 Never Married 2 Married Armed Forces?					s Deceder es, specify							e - Ameri e, etc.	can Indian, Black,			
or ite	Fune				1 Yes	2 📉 No		Yes 2	, No	specify:				Specify:	ity: Asian			
s afte	ā	3 Widowed 4 15. Decedent's Educatio			Yes, Give Year or Dates: highest gra		16a. Deceder				ind of wo	rk done	16	6b. Kind of Business/Industry				
2 hour "natt	eted	Elementary/Secondary				1-4 or 5+)	during most of working life. DO NOT use retire											
thin 7.	pdu	10th grade			na		Dr	iver					1	Pizza	a B <mark>olis</mark>			
215-0036 be filed within 72 hours after death with the Maryland mall Hygiene. rked other than "natural", or items 23a or 28a-f sheart, the Medical Examiner must be notified at once	Comple	17. Father's Name (First, I		, Last)					11	B.Mother's	Name (First, Midd		den Surname				
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner	a	Rasool Bux					T. (2) 12 11			odi		and Davids	N I come have a	, City or Tov	- Ctoto	Zin Codo\		
MD 21 2 should h and Me 27 is ma imatic ev	-	19a. Informant's Name/Re														21.	244	
무급등		Murtaza Ah 20a, Method of Disposition		d-Fr	riend	20b.	Place of Dispos	Che sition (Nam				Date	W1 1	odsor oc. Location	- City or	Town, State		
Baltimore, Moemir. Pages I and 2 Department of Health Important: If item 2 injury or other traus		1 Burial 2 Cre		n 3 🗌	Removal f	rom State	crematory or ot			1		F /06			och ist	istan		
t. Pag tment tment		4 Donation 5 0 21. Signature of Funeral S	ther S	pecify:	- 1		Jhat		Address			5/20)TD	rak	ISC			
Baltimo permit. Page Department of Important:		Doma	M	(1)	Jan	all		Name and A								21215		
Physician	1	23a. Part I. Enter the dise	ase, o	r complic on each	ations that on line.	caused the deat	h. Do not enter t	he mode o	fdying, s	uch as ca	rdiac or	respiratory	arrest,	shock, or he	eart	Approximate Inte Between Onset		
/Medical ≟xaminer	1	Immediate Cause (Final c				nds (2) of To										Death		
		or condition resulting in d	eatn)	Du	ue to (or as	a consequence	of):											
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):																
	Examiner	cause. Enter Underlying (Disease or injury that init	of):															
ansit and		events resulting in death)	Last	d.	de to (or as	a consequence												
be executed sician and urrial - transit	dical	UNPENDED			AMENDED	MENDED												
ox 68760 eath certificate b attending physi for use as the bu	/Me	IF FEMALE: 23b. Was decedent pregna	ant in 1	the		outcome of pre			3 [Ectopic	pregnan	CV		23d. Date of Month		/ Day Year		
certification of the second	cian/Me	past 12 months?	J. 17.		1 Live	ыπп nant at time of α	2	etal death ther <i>(Sp</i> ec			pregnan	Су		WOTE		,		
Box 68760 e death certificate bette attending physical for use as the buse	Physic	1 Yes 2 No 9	Ur	nknown	9 Unkr	nown												
P.O. Es that the danger of detached	by Pł	Part II. Other significant	condi	tions o	contributing	to death but not	resulting in the	underlying	cause gi	ven in Par	rt I.					the cause of death		
w requires that is been signed by should be detay	ted			_								24a. V	Vas an	24b.	Were au	topsy findings avai	lable	
cords law requi	Completed											р	utopsy erforme		death?	completion of cause		
tal Rection: The lector, page	Co								20 01	- f D 4h- ((Ob a als as		es 2	No No	1 🗸 Ye	es 2 N)	
of Vital Records, g Physician: The law requir ther this certificate has been si neral director, page 2 should b	Be	25. Was case referred to examiner?		_	spital: 1	Inpatient 2	✓ ER/Outpatien			of Death (Home 5	Re	sidence 6	Othe	r:		
of Vision Physics ter this eral dir	. To	1 Yes 2	No	<u> </u>	28a. Dat	e of Injury	28b. Time of		28c. Injun	y at Work				v injury occu	пед			
on on on on on on on on on on on on on o	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 1 Modernined 2 Suicide 6 Could not be determined 1 Modernined 2 Suicide 6 Specify) Local Street 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 32b. Time of Injury 4bb. Time of Injury 32b. Time of Injury																	
Division Hospital or Attendin 24 hours after death. Funeral Director:	fica	2 Accident 3 Suicide 6	_	estigation uld not be	28e Pla	ce of Injury - At		et, factory	office bu	uilding, etc	c. :				ber or Ru	ıral Route Number,	City	
Divinital of ours affilled i	Suicide 6 Could not be determined (Specify) Local Street or Town, State) 1847 Meade Village Circle, Severn, MD																	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical C	29a. Certifier 1 Certifier one) 2 Medi	fying I	Physicia aminer:	n: To the be	est of my knowle s of examination	edge, death occu and/or investiga	urred at the ation, in my	time, da opinion,	te and pla death oc	ice, and o	due to the the time, o	cause(s date and	s) and manne d place, and	er as stat due to th	ed. ne cause(s)		
To the within 2 To the complet	Med	29b. Signature and title o			and manner	stated				number	-					nth, Day, Year)		
		wi			5	>			O.C.N	Λ.E.] [Decembe	r 19, 2	010		
2		30. Name and address of	perso	n who co	ompleted ca													
		Ling Li, MD A	ssist	ant Me	dical Exa		1 Penn Stre	et, Balti	more, I	MD 212	01							
S	tate	31. Date filed (Menth, Da	WY T	1	32. F	Registra s Signa	and											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

] 	State Registrar Decedent's Name (First, Middle,	Last)		Certi	ficate of	Death	2. Date of De	Reg. No.		3. Time of Death
Physicia	n	Linda		·v1	Ford			Dec.	13	2010	7:32 P M
/Medica Examine		a. Facility Name (If not institution,		-		lb. City, Town, o	r Location of Death			ounty of Death	,,,,,,
Examin.		941 Martin Road	l			Ess	éx		B	altimor	re Co.
Funeral	5		.Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. last		If Under 1 Year Months Days		8. Date of Bir (Month, Da June I	th Y Year)	9. Birthi	place (State or Foreign ntry) 'Yland
rector		212-78-9883 Usual Residence of Decedent		50	110.			Julie 1	J, 190	U Flat	yrand
In patition at		0a. State 10b. County		10c. City, T	own or Locat	tion					10d. Inside City Limits
diffe	Director		timore		Esse	x					1 ☐ Yes 2 🐴 No
20 I	Dire	0e. Street and Number	a			10f. Zip Code	21221		_	n of What Cou ed Stat	•
	Funerai	941 Martin Roa		edent Ever in U.S.	13 Wa			acify Yas or No		Race - Ameri	
	ᇤ	1 Never Married 2 Marrie	Armed Fo	orces? 212 No			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White,	
:	δq L	3 € Widowed 4 Divorced	If Yes, Gi Year or D	ates:		Yes 2√∑ No			St	oecify:	White
	Completed	15. Decedent's (Specify only highest	Education grade completed)	1	6a. Deceden (Give kin	nt's Usual Occup nd of work done	pation during most of work d)	ing	16b. Kind	of Business/In	dustry
	ᇤ	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+)		emaker	u)		Qwi	n Home	
1	ည် ရ	7. Father's Name (First, Middle, La	ist)				18. Mother's Nam	e (First, Middle,	, Maiden Su	ımame)	
	0 0	Melvin Kramer					Dolor	es Icen	road		
		19a. Informant's Name/Relationshi Mrs。 Deborah Sc					and Number or Rur Hill Cir				7331
	2	0a. Method of Disposition	ПВ	nom.	e of Disposition	on (Name of tory or other pla	ce)	Date	20c. Loca	tion - City or To	own, State
		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	city)	Hill	Ltop S	ervice	Corp. 12/	17/2010	Tow	son, Ma	ryland
any injury or other traumatic evonce.		21. Signature of Fungral Savin Ligensee Duda-Ruck Fungral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland									
	+	23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that of	caused the death.						and 21	Approximate Interval Between
an		Immediate Cause (Final disease or condition		inquinat	Tian (1	eg Wow				Onset and Death
cal		resulting in death)		(or as a consequen	ce of):	1.0%	2	. ()			
er		Sequentially list conditions	b								
	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequent	ce or):						
	Exar	hat initiated events esulting in death) Last	c. Due to	(or as a consequen	ce of):					-	
	ca		d								15 65 × 10 0.2 00 60
	Med	F FEMALE:								1	
	- 1	23b. Was decedent pregnant in the past 12 months?	1 Live t	tcome of pregnancy pirth 2 Fetal dea	ath 3□Ec	ctopic pregnanc	/		230	d. Date of deliv-	ery Day Year
	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4∏Pregr 9∏ Unkn	nant at time of death own	5 🗆 🔾	ther (specify) _				14101111	Duy Fau.
i	7	art II. Other significant condition	s contributing to d	eath but not resultin	g in the unde	erlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
	ַ בּ							10	Yes 201	No 3□ Prot	bably 4 Unknown
	olete							24a. Was		24b. Were auto	ppsy findings available
	Completed							autor perfo	osy irmed? 2/2 No	death?	mipletion of cause of 2□ No
		25. Was case referred to medical examiner?					26. Place of Deat				
1	2	1XYes 2□ No				3□ DOA Dt	4 Nursing Ho				
		7. Manner of Death 1 Natural 5 Pending	- L	of Injury th, Day Year) 281	b. Time of Injury	28c. Injur	y at	100	. 1	occurred e_{X}	sanguingtien
	Icat	2 Accident investiga 3 Suicide 6 Could no	be One Diese	of Injury - At home			Yes 2 No	28f Location (Street and h	lumber or Run	al Route Number,
	Certification;	4 Homicide determin	buildi	ing, etc. (Specify)	-	, ractory, unice		City or To	vn, State) G	141 Mant	n Read
		(Check only 2 Medical Ex	aminer: On the b	a best of my knowled asis of examination	dge, death od and/or inves	ccurred at the ti	ne, date and place, ppinion, death occur	and due to the red at the time,	May cause(s) an date and pla	nd manner as s	stated.
		one) 9b. Signature and titte of certifier	and man	ner stated.		29c. Licens				signed (Month,	
		Litalith .	100	- 1.		NIO	1.1.7			1	
-1	X	O. Name and address of person wi	no completed caus	se of death (trem 23	a) (Type Pri	nt)	1 99			ben 14,	
1	and the same of			,	A . A	5	1.6	(1)	A.		
4		Philip Militel	WMD (egistrar's Signature	le 4)	ill CT.	Ly fleru:	lle.M	() Z	1093	}

10-0964	1	
Mellissa	Ann	Fox

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 40247 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Examiner 1422 hrs December 14, 2010 Ann Fox Mellissa 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 1109 Old Eastern Avenue Apt. D **Baltimore County** 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Months Hours Min Director Country) MD 216-86-8802 Feb. 3,1971 39 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show Essex Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. D 1109 Old Eastern Ave. United States 21221 Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 1 Yes 2 X No 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 X No specify: Specify: White 2 or Dates Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene Inportant: If Item 71 is marked other than "natura injury or other traumatic event, the Medical Examin 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Health Care Elementary/Secondary (0-12) College (1-4 or 5+) Medical Medical Assistant 12 Years 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Margaret Jean Brockwell Be Raymond Nelson Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ray Valentine (Father) 2807 1st Street Millers Island, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sacred Ht. of Jesus Cem. 12/18/2010 Dundalk, Maryland Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21222 2 Dundalk, Maryland 7922 Wise Ave. Approximate Interval Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Between Onset and /Medical Death Oxycodone and alprazolam intoxication Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last physician and the burial - trans Physician/Medical AMENDED X UNPENDED 3a,27,28a-f,per ME G911 1/3/11 TT The law requires that the death certificate be Box 68760. IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page 2 certificate ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital Be Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene After this 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey,Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural pm¹ Yes 2 X No Director: , 5 Pending death. unknown Fd 12/14/10 Fd 12:19 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1109 Old Eastern Av. Apt D Essex, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 A Could not be 3 Suicide residence thin 24 hours at determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 15, 2010 O.C.M.E. Brownell 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State o	f Maryla	nd / Depa	artment	of H	lealth a	and M	lental Hy	gien	е			
		•	State Registrar			Cei	tificate	of D	eath			Reg. N	0.201	n	1.021.9	
	Dhusisis	_/	1. Decedent's Name (First, Middle,	Last)			_				2. Date of Dea		lay Yea	r	3. Time of Death	
	Physicia Medic		BARRY ROBERT	FRIEDMA							DECEMBI	ER 1	6, 201	0	11:46 A ^M	
}	Examin	er	4a. Facility Name (if not institution, g				4b. City, To			of Death		4	c. County of De		_	
ALL PARTY			205 EAST JOPPA 5. Social Security Number 6		PT . 210 7. Age (In yrs.		T(OWSO	N If Under	24 Hrs.	8. Date of Birt	h	BALTI		E ace (State or Foreign	
	Funeral Director		121-34-8399	1 4 M 2 D F	66	Yrs.		Days	Hours	Min.	03/14/		4	Countr		
			Usual Residence of Decedent											_		
9	rand F show d at	to	10a. State 10b. County		10c. C	ity, Town or Lo	cation							10	d. Inside City Limits	
4	Mary 28a- notifie	Director		IMORE		rowson								┸	1 Yes 2 No	
4	3a or	10e. Street and Number 10f. Zip Code								10g. C	Citizen of What	Countr	y?			
44	ms 2 mus	Funeral	205 EAST JOPPA		PT. 210 Ident Ever in U			1204		nin? (Sne	cify Yes or No-		USA	OA ace - American Indian,		
•	or ite	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	Armed Fo	rces?		f Yes, specif						Black, W			
3	ral", Exar		3 Widowed 4 X Divorced	If Yes, Giv Year or Da	e		1 🗌 Yes 2	[XNo	Specify:				Specify:	WH	ITE	
	"natu dical	Completed	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usual kind of work	Occupa	ation	of workii	na .	16b.	Kind of Busine	ss Indu	stry	
7	nin /2 ne. than 'e	mo	Elementary/Seconday (0-12)	College (1	-4 or 5+)	Ìife. D	O NOT use r	retired)	Ü	01 1101111	.9					
۱ <u>ا</u>	d wir dygie ther nt, th	Be C	17. Father's Name (First, Middle, La.	<u> </u>		ADM	INIST	KATO T		aula Niausa	/Final Ministra		LNSURAN	CE		
5	should be liled within 7.2 hours after death with the inaryland and Mental Hygiene I is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at	To E	BENJAMIN	F.	NT.	18. Mother's Nan					ame (First, Middle, Maiden Surna `A N			FRUCTMAN		
, i	mari mari		19a. Informant's Name/Relationship		KILDIHII	1	na Address (Street a			Route Numbe	r. City c	or Town, State.			
N S	and 2 sn Health ar tem 27 is		BRYAN FRIEDMAN								EAST WI				520	
ָנ ב	item		20a. Method of Disposition			Place of Dispo	sition (Name	e of			ate		Location - City	or Tow	n, State	
	rage I ment of ant: If it ury or o		1 🎇 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp		State BI	ETH ISR				12/19	/2010	W	OODBRID	GE,	NJ	
חמו	permit. Fage I and z should be filed within /z hours after death with the maryland pagetrhent of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Ac	ensen HII			2. Name and			50	ROAD,					
		_	23a. Part 1. Enter the disease, or c	omplications that of	caused the dea						-		<u> </u>		Approximate	
∗ Di	h sician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition (Cardia)											nterval Between Onset and Death		
	Medical		disease or condition resulting in death)	a. Due to	or as a conse		1.9[1000	ııq						+	Se(0.74)	
	Examiner		Carriantially list conditions	h	(0)	monary	arkn	1 1	HREESR	Š				`	flors	
		Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	or as a conse	quende orj.		1	XX (\$1 e = 0.3)							
4	und transi	xan	Cause (Disease or iinjury that initiated events c.													
9	ohysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):													
3	physi	edic		d												
3	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			7						23d. Date of	deliver	У	
	e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🔲 Preg	Birth 2 Fe		☐ Ectopic pr☐ Other (spe		У				Month		Day Year	
, q	by the	hys	9 🗆 Unknown	9 🗀 Unkr												
that a	signed by the a	by	Part II. Other significant condition	s contributing to d	eath but not re	esulting in the t	inderlying ca	ause give	en in Part	1.					cause of death?	
ָרָט . פַּרִייִייִם	should k	ted									1 🗆				ably 4 🗆 Unknown	
	nas bi	Completed									24a. Was autor			to com	sy findings available pletion of cause of	
P 4	cate pag		05.11								1 🗆 Yes				□ No	
iciai	certif	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		7		Othe	r;			-				
2 4	er this	e: To	27. Manny of Death	28a. Date	of injury	ER/Outpaties 28b. Time of		c. Iniury	at		me 5 PResid 28d. Describe h			еспу)		
a suiga	ath. r: Affe e fun	icat	1 Natural 5 Pending 2 Accident Investiga		th, Day, Year)	injury	М	work?	? Yes 2 ☐	No						
or Attending Division. The law requires that the death certificate he executed	recto by th	Certificate:	3 Suicide 6 Could no 4 Homicide determin	28e. Place	of Injury - At h	nome, farm, str	eet, factory,	office			28f. Location (S City or Tow			Rural F	Route Number,	
	vurs aft															
To the Hoenital	to the tropped of standarding reported in the law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical Ex	aminer: On the bas Surse Practioner:	is of examinati	ion and/or inves	tigation, in m	ny opinio	n, death o	curred at	the time, date a	ınd plac	ce, and due to the	ne caus	e(s) and manner stated.	
2	Withi To the	-	29b. Signature and title of certifie				29c.	-	number			29d. D	ate signed (Mo	nth, Da	ay, Year)	
			1	Win				V	15716	9		- Id	e centr	16	(010	
			30. Name and address of person w	ho completed caus	se of death (Ite	m 23a) (Type, I	Print) Sui	k 7	lo		(Menlum,	N	7 21093			
	Stat Registra		31. Date filed (Month, Day, Year) DEC 21 2010	Seneva 32. R	egistra s Sign	attere de la la la la la la la la la la la la la	6.		_							
			Mark May make	Last Land	1 (1											

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19 Day Physician/ 2010 ALLEN H. GOSNELL, JR 40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7612 Beaver Rd. Glen Burnie Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 **X** M 2 □ F Hours 09 02 1923 5900 87 216 12 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director** 1 🗌 Yes 2 🔀 No Glen Burnie MD Anne Arundel 10e. Street and Numbe 10g. Citizen of What Country? ō U.S.A. 7612 Beaver Rd. 21060 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 X Yes 2 No 1942 Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates þ 1 Never Married 2 Married "natural", or Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 1945 White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Fire Fighter <u>Fire Department</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Allen Hussell Gosnell Marie Matilda Koehnlein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once, Beverly Goray daughter 912 Dogwood Rd. Glen Burnie, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Haven Mem Pk 12/22/10 Glen Burnie, MD 22. Name and Address of Facility GJ Gonce Funeral 21. Signature of Fundral Sorvice Licensee 169 Riviera Dr. Pasadena, 23a. Part 1. Entur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 34ea-5 ementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 2 weeks Preumonia Sequentially list conditions, if any, leading to immediate caus: Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): lysician and ne burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the phy attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 A Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending after death. 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R118354 Schalen cars 20/2010

State

DHMH 17 Rev 7/2009

Registrar

Point

Pasadina mo 21122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP

7900

32. Registrar's Signature

Oak

Schuler

2010

31. Date filed Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30AM Medical 4a. Facility Name (if not institution, give street and number) 40. City. Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 №M 2 □ F Months Hours Min. (Month Day, Country) Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director notified 1 Yes 2 No ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 ₩idowed 4 Divorced Completed)/ac permit. Page 1 and 2 should be filed within 72 mount.
Department of Health and Mental Hygiene.
The Page 1 is marked other than "ratur." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Air 20a. Method of Disposition 20b. Place of Disposition (Name of 26c. Location - City or Town, State tery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Funeral Services 728 allstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause a mach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MURICILLA Medica! Tue to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown should Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has 1 Yes 2 No Yes 2 NO 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? infuprhent Kom Hospital 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of cer 29c, License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Smoth

address of person who completed cause of death (Item 23a) (Type, Print)

2835

32. Registrar's Signature

Werly

W.

KANKEN

31. Date filed (Month, Day

80043375

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-09679 State of Maryland / Department of Health and Mental Hygiene Bobby Gene Geddings, Jr. 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 2308 hrs Medical Examiner Geddings, Jr. December 15, 2010 Bobby Gene 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Country) Months Days Hours Director 01/22/1952 SC 1 X M 2 F 58 212-60-0729 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits any 1 Yes 2 No or 28a-f show Glen Burnie Anne Arundel Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 U.S.A. 610 Stephanie Court Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 1 Yes 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical 21215-0036 Construction Contractor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Williams Geddings, Sr. Barbara Jane æ Gene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Father 610 Stephanie Court Glen Burnie, MD Mr. Bobby Gene Geddings, Sr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State crematory or other place) Glen Burnie, MD 12/18/2010 Atlantic Crematory Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licensee 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Alcohol and narcotic intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit the Hospital or Attending Physician: The law requires that the death certificate be executed hysician/Medical X UNPENOED the attending physician ed for use as the burial -AMENDED 27.28a-f. per EM g910 12/22/10 TT Box 68760, JE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown 9 Unknown P.O. 亩 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed Division of Vital Records, has been 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No death? certificate 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) 8 Hospital: 1 Inpatient 2 PER/Outpatient 3 DOA Other this 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death ___ Natural neral Director: , filled in by the fi 1 Yes 2 X No unk Pending Fd 12/15/10 Fd 11:00 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 610 Stephanie Ct Glen Burnie, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide determined residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa within 2 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 16, 2010 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 23:48 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOPKINS JOHNS BATVIEW HED COR BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Maryland -07-041 91 Hours Director 9 .1919 Usual Residence of Decedent 23a or 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director MU 1 Yes 2 No Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1958 Sunberry Road 21222 items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, ٥ 1 Never Married 2 Married þ 1 Yes : 2 XVo Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States College (1-4 or 5+) Elementary/Seconday (0-12) Government 11 years Index Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude B. Basel George R. Haas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 174 Penn Lear Drive, Monroeville, Pennsylvania 15146 Daughter Carol Lanzer Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 20, 2010 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundal Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AUDOSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Month 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 1 ☐ Yes 2 ☐ No or Attending Physician: of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Ninpatient 2 🗆 မ ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury 28h Time of 28c. Injury at 28d. Describe how injury occurred : After 1 1 Matural (Month, Day, Year) 5 Pending work' Division 1 Yes 2 No within 24 hours after death To the Funeral Director: 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Under the date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the ! only one) 29d. Date signed (Month, Day, Year) 12 - 18 - 2010. 29c. License number 29b. Signature and title of certifie D 70738

Registrar

State

PONOR

31. Date filed (Month, Day, Year)

2010

se of death (Item 23a) (Type, Print), MD 5200 EASTERN NE. BALTIMORE, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Anita Bernice Gay <u>December</u> 2010 4:00PM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dove House Hospice Westminster Carrol1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 28 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Min 1 M 2 X F Hours 89 Yrs. Director 220-05-9303 Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 X No MD Baltimore Reisterstown 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 126 Cherry Valley Road 21136 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. ò Completed by 1 Never Married 2 Married 2 💢 No 1 Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: "natural" 3 X Widowed 4 □ Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Sales Person Retai] Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ be John Koehne Lorraine Pfeiffer Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathie L. Elburn Daughter 126 Cherry Valley Road, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Dog 5 Other (Specify) Carroll Cremation 12/15/201d Hampstead, 21. Signat vice Licer 22. Name and Address of Facility 11824 Reisterstown Road J. Wayne Osterling Eline Funeral Home Reisterstown, MD 21136 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart fail Imm liste Cause (Final disease or con Fion resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregrant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Pregnant at time of death 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Mue Mis Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ₁ ☐ Yes 2 🗌 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No INPATIENT မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours

State Registrar DHMH 17 Rev 7/2009 29a. Certifler

(Check

only oh

31. Date filed (Month, Day, Year,

and title of certifie

who completed cause of death (Item 23a) (Type, Print) SI

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

wesommeron.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD 2/15

29d, Date signed (Month, Day, Year)

License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 1410 December Medical 4a. Facility Name (if not institution, give street 4b. City, Town, or Location of Death **Examiner** OFTHE ANNE resorrake HOSPICE. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months -30 1 □ M 2 Hours the Day **Director** and Usual Residence of Decedent or items 23a or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director towari 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country Funeral 20 30 (TWITTOR 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify 3 🗌 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during dfe. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) State Government Elementary/Seconday (0-12) Docial WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) 2 Name/Relationship (Type, Print) 000 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -22-2010 CEMETERY e of Euperal Service License Signatu 000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as Approximate Interval Betwo shock, or heart failure. List only one cause on each ine. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 - Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No injury **₽** atural Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For	Plea				id / Dep	artmei	nt of H	lealth		II Copie Mental Hy			jible.	1.0055
		State Registrar					Ce	rtificat	e of D	eath			Reg. N	اه. ۲ــــــــــــــــــــــــــــــــــــ	110	40255
Physicia	n/	1. Decedent's Name				TT 7	100					2. Date of De Decemb		ay6 2	n ye r o	3. Time of Death
Medic	al	Edward		illia			ller	4h City	, Town, or	Location	of Death	Decem	-	<u> </u>	of Death	11:10p ^M
Examin	er	4a. Facility Name (if		-		11)		1	letho		TOT Death				timor	e.
Funeral		5. Social Security N	Leads !	6. Sex	7.	Age (In yrs. I	ast birthday	If Unde	er 1 Year	If Unde	r 24 Hrs.	8. Date of Bir				place (State or Foreign
Director		215-01-0	0738	1 X N	1 2 □ F	96	Yrs.	Months	Days	Hours	Min.	(Month, Da 08/06	719	14	Mar	yland
d how tt	_	Usual Residence of 10a. State	Decedent 10b. County			10c. Cit	ty, Town or L	ocation.				-				10d. Inside City Limits
arylan a-fst fied a	ecto	Md.	Ralt	imor	_	Ha	aletho	rpe								1 🗌 Yes 2 🗚No
or 28 or 28 e noti	ä	10e. Street and Nun		LINOI		110	1100110		ip Code		_		10g. 0	Citizen of	What Cou	ntry?
with with s 23a ust b	Funeral Director	1238 Lea	ads Te	race				2	1227					USA		
death item:	Fur	11. Marital Status			Was Decede Armed Force	es?	S. 13	. Was Dece If Yes, spe	dent of Hi	spanic O n, Mexica	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)	-		ce ~ Americ	
after (Completed by	1 ☐ Never Marr 3 ☐ Widowed			1 XYes 2 If Yes, Give			1 🗆 Yes	2 N 0	Specif	iy:			Specify	· Whi	te
atura cal E	etec		15. Decede	nt's Educa		s.	16a. Dec	edent's Usi	ual Occupa	ation			16b.	Kind of E	Business In	
n 72 h an "n Medi	ld m	(Specification)	ecify only high	est grade o	completed) College (1-4	or 5+)		e kind of we DO NOT us		luring mo	st of work	ing				
withii giene rer th t, the		12			2		Sel	f emp	loyec	_					are S	tore
e filed ttal Hy ed oth event	To Be	17. Father's Name (e (First, Middle Schmac		n Surnar	ne)	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.			iam Ha]		Drint\		10h M	:1: A alalas	na (Stroot i	_		al Route Numb		or Town	State Zin	Code)
2 sho th and 27 is r traun		19a. Informant's Na										lethor				
and Heal tem 2	ريد	Anne Hu 20a. Method of Dis	position			20b.	Place of Dis	position (Na	ame of			Date	_			own, State
age 1 ent of nt: If i y or c		1 X Burial 2			moval from S	iaie	cemetery, cr				12/2	0/2010	B	altir	more.	Maryland
mit. P bartm bortar / injur		21 Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc.														
permi Depar Impo any ir		ボア	23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
		23a. Part 1. Enter shock, or hea	the disease, ourt failure. List	r complica only one c	tions that car ause on each	used the dea line.	th. Do not e	nter the mo	de of dyin	g, such a	as cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death
Physician/		Immediate Cause disease or condition		a.	\Box D	CM	EN	TIA								YR.
Medical Examiner		resulting in death)		ſ	Due to (or	as a consec	quence of):									
	ē	Sequentially list co		b.	Due to (or	as a consec	quence of):									
ted nsit	Examiner	Cause (Disease or	intyling injury	•			_								- 1	
executed an and rial-transit	Ě	that initiated events resulting in death) Last C. Due to (or as a consequence of):														
ath certificate be executed attending physician and for use as the burial-transit	lical			d.												
tificat ng ph	Physician/Medica	IF FEMALE:		-				_								
th cer ttendi or use	ian/	23b. Was deceden in the past 12		230		irth 2 Fe ant at time of	tal death	Ectopio		су					ate of deli Ionth	very Day Year
the all	ysic	1 Yes 2 9 Unknown	No		9 Unkno		deam :) Li Other (specify)							
hat th ed by detac	y Ph	Part II. Other signi				ath but not re	esulting in th	e underlyin	g cause gi	ven in Pa	ırt I.	23e. Did	tobacc	o use cor	ntribute to	the cause of death?
ires the sign	Completed by	HYF	ERTE	ens	SION							1 📗	Yes	2 No	3 🗆 Pr	obably 4 🗆 Unknown
v requ	olete											24a. Wa	s an opsy	24b	. Were aut	opsy findings available ompletion of cause of
he lav te has age 2	mo						_						formed.	2. No	death?	Service of
an: T	BeC	25. Was case refer	red to medica								eath (Che	ck only one)	_			
nysici nis ce I direc	10	examiner?	No	Hos	spital:	npatient 2	1			4 ⊔	Nursing H	lome 5 Re				fy)
frer th		27. Manner of Dea	th 5 🗌 Pend	ing	28a. Date of (Month	f injury , <i>Day, Year)</i>	28b. Time injur	y	28c. Injur wor	k?	□ N=	28d. Describe	how in	jury occu	rred	
ttendi death tor: A	Certificate:	2 Accident 3 Suicide	Inves	tigation d not be	28e, Place o	of Injury - At I	nome farm	M street, facto		Yes 2	□ NO	28f. Location	/Street	and Num	ber or Run	al Route Number,
or Atlanta	Cerl	4 Homicide	deter	mined	building	g, etc. (Speci	ify)	gtioot, idos	31), 011100			City or To				
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but		29a. Certifier	1 Dertifyir	g Physici	an: To the be	st of my kno	wledge, dea	th occured	at the time	e, date ar	nd place, a	and due to the	cause(s)	and mar	ner as sta	ted.
n 24 h	Medical	(Check only one)	2 Medical 3 Departuri	Examine g Nures	r: On the basis ractioner: To	of examinati the best of i	ion and/or in my knowledg	estigation, e, death oc	in my opini curred at tl	ion, death he time, d	ate and pla	at the time, date ace, and due to	the caus	se(s) and o	manner as	ause(s) and manner stated stated.
Vithi Vom	-	29b. Signature and	Att of contiff)			2	9c. Licens	se numbe	7 7	0	29d.	Date stgr	ned (Mo) th	, Day, Year)
			MA	1	M				بر	20,	~~~ ~~~	7	L,'	×/ 1	11'	
j		30 Name and add	ires of perso	who com	pleted cause	of death (Ite	em 23a) (Typ	Cont) L	VILLE	EN	8 K	WE.	B	127.	M	D 21729
		31. Date filed (Mor	oth, Day Year	16411	32 Pa	gistrar's Sign	nature -	00 0								
Sta Registi		nFC	2 1 20	10	Re see	J.	Loan	Can't								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HOLMES SESUBSI 13 5:30 P M SHIRLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care of Cherrywood Baltimore Reisterstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🎦 F Months Hours 271371935 Country) MD Director 75 220-30-4008 Usual Residence of Decedent items 23a or 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11818 Ivy Mill Rd. 21136 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Middle School Carroll Co. Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Grace Lee Grady French Lee Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11818 Ivy Mill Rd., Reisterstown, MD 21136 George Holmes/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite cemetery, crematory or other place 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet. Cem. 12/17/10 Owings Mills, MD 21. Signature of Funeral Service Licenses 22 Burrier Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Call LUNG CANOSK WITH BRAID METASTASI Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by PROTIC CORMANY VASCULAR Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No 1 Yes Investigation neral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completed filled in by determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 9088852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smin Rumus #203 (Snipinus Maryland 21209 NOWLEN C. DIAMOND

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

0

32. Registrar's Signature

10-09763		Ple		or Print in B						ble.	
Alethea Hawkins		1- For State	Stat	e of Maryland	/ Departmen			ientai Hyg	iene Reg.	ZUIL	1 6705
Physicia Medical Examin	n/	1. Decedent's Nam	e (First, Middle, l	ast)					Date of Death)av Year	3. Time of Death 0518 hrs
			if not institution, Monument St	give street and number)		r, Town, or Locat		occomber_	4c. County of Dea	th
Funeral		5. Social Security N			ge (In yrs. last birthd					(MM/DD/YYYY) 9. B	
Director	4	214-86-8 Usual Residence o	, ,	M 2 X F	38	Yrs. Mor	nths Days H	lours Min.	11/08/		ountry) MD
d how any		10a. State	10b. County		10c. City, Town or						10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Nu	1 1	ment S	troot		2ip Code	タ	10g	. Citizen of What Co	untry?
with th	힏	11. Marital Status		12. Was Deceden			dent of Hispanic	Origin? (Speci			rican Indian, Black,
r death w	Funeral	1 Never Marri		1 Yes 2	No X		cify Cuban, Mex		an, etc.)	White, etc.	lank
ırs after tural",	<u>a</u>	3 Widowed 15. Decedent's Ed		or Dates: only highest grade co	mpleted) 16a De		2 No spe al Occupation (G	Give kind of work		Specify: (F) 6b. Kind of Business	/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Second 12+	ondary (0-12)	College (1-4 or	5+) dui	ring most of w	1 40	ard		City of	Raltimere
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	8	17. Father's Name	(First, Middle La	gene Hûw	kins		18.Mo	other's Name (Fi	rst, Middle, Ma	iden Surname)	
MD 21 42 should th and Me a 27 is ma umatic er]۲	19a. Informant's Na	e Rob	bitt Mo	ther 31	Mailing Addre	SS (Street and	Number or Rura	Balti.	er, City or Town, Stat MOVE, Md-	2/2/4
altimore, MD Z rmit. Pages 1 and 2 shou ppartment of Health and portant: If item 27 is jury or other trauman		20a. Method of Dis 1 Burial 2	Cremation			Disposition (N or other place	ame of cemetery	12/2	ate ///	Balto.	Town, State Wary land
Baltin permit. P Departme Importan injury or	ŀ	4 Donation 5 21. Signature of Fu			7	22. Name ar	nd Address of Fa	TIOONO	FS	4905 G	PK Road
Physician	+		ne disease, or co	mplications that caused	d the death. Do not e	enter the mod	e of dying, such	as cardiac or re	spiratory arrest	, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (or condition resulti	(Final disease	a. Gunshot Woun							Death
		Sequentially list co		b.	equence or).						
	Examiner	if any, leading to in cause. Enter Unde (Disease or injury t	erlying Cause	Due to (or as a cons	equence of);						
scuted transit		events resulting in		Due to (or as a cons	equence of):						
	dical	UNPENDED		AMENDED		-	_				
68760, certificate be ex-	/We	IF FEMALE: 23b. Was decedent		23c. If yes, outco	me of pregnancy	Fetal deat	h 3 Ed	topic pregnancy		23d. Date of deliver	y Day Year
that the death certificate be need by the attending physic deached for use as the burn	Physician/Medic	past 12 months 1 Yes 2 I			t time of death 5	Other (Sp					
Records, P.O. Box The law requires that the death icate has been signed by the atte	<u>a</u>	Part II. Other signi	ficant condition	s contributing to deal	th but not resulting in	the underlyi	ng cause given i	n Part I.		cco use contribute to	the cause of death? bably 4 Unknown
Division of Vital Records, P.O is or Attending Physician: The law requires that the staffer death. **I Director: After this certificate has been signed by the funeral director, page 2 should be deacont.	Completed								24a. Was an autopsy		utopsy findings available completion of cause of
Recol The law icate has	ĕ			 · ·			_		performe 1 Yes 2	ed? death?	es 2 No
ital Recicion: The scertificate rector, page	Be	25. Was case refer examiner?		Hospital:	ent 2 ER/Outp	atient 3	26.Place of De	ath (Check only		esidence 6 🗸 Othe	or: Scene
of Vil	٤	1 Yes 27. Manner of Deat	2 No th	28a. Date of Inj	ury 28b. Tim	ne of Injury	28c. Injury at V	Vork? 28	d. Describe hov	v injury occurred	
tion ttendin death. ctor: A y the fu	ation	1 Natural 2 Accident	5 Pending Investig	ation Dec 18, 2010	0431 h	rs	1 Yes 2	No No	bject was s		
Divisior al or Attend s after death al Director: ed in by the	Certification	3 ☐ Suicide 4 ✔ Homicide	6 Could n	ot be	njury - At home, farm wnhouse / Row		ry, office building		or Town, Stat		ural Route Number, City more, MD
hou hou		29a. Certifier 1 (Check only		sician: To the best of m	ny knowledge, death	occurred at t		d place, and due	to the cause(s	s) and manner as sta	ted.
To the within To the comple	Medical	one) 2 ✓ 29b. Signature and		ner: On the basis of exa and manner_stated	mination and/or inve		9c. License num			9d. Date signed (Mo	
		4	4 4	i, up			O.C.M.E.	-		December 18, 2	
6	f	30. Name and addr Ling Li, MD	·	no completed cause of	,	 Street, Bal	timore, MD 2	21201	<u>_</u> 1		
Sta		31. Date filed (Mon.		22. Registra	ar's Signature	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 December 12:09A M Arthur Robert Hendricks. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert. Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 X M 2 D F Hours (Month Bay Year) 1921 New York Director 169-12-6856 89 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 🗌 Yes 2 🔀 No Charles Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a c any injury or other traumatic event, the Medical Examiner must be once. 29449 Charlotte Hall Road 20622 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Automotive Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ္ George Hendricks Bessie Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Thompson / Daughter 2456 Davidsonville Road, Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 12/17/2010 Hanover, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the Nicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Bilateral disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Secure itelly list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Hewit 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Renal Failure autopsy 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 \square Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

UYERNA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C SU1219 NA

32. Registrar's Signature

D. 50653

Deale MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Sta	te of M	laryland		irtment tificate			and M	lental Hy	giene Reg. No.	2010	+0	259
	Physicia		1. Decedent's Name (First, Mi	ddle, Last) HARE								2. Date of De Month	eath Day	Year		of Death
	Medic Examir		4a. Facility Name (if not institu		nd number)			4b. City, 1	Town, or	Location o	of Death	Decry		County of Dea		C3 F
-	<u>'</u>		UNIVOUM OF M							ORE-				altimo		
	Funeral Director		5. Social Security Number 215-30-9252	6. Sex 1 😾 M 2		ge (In yrs. last 78	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 8 / 26 / 1	th a <i>y, Year)</i> I Q 3 2	Co	thplace (Stat untry) urvlan	J
	show d at		Usual Residence of Decedent 10a. State 10b. Cou			10c City	Town or Loc	ection				0/20/				City Limits
	larylan 8a-f sh iffied a	ecto		timore			ansdow									Yes 2 X No
	a or 28	Funeral Director	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What Co	ountry?	
	th with ms 23 must	ıner	819 Rambo (5 I II 0	140.11			21227				nited S		
21215-0036	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 3 Widowed 4 Divo	Married 1 If Ye	Becedent ned Forces? Yes 2 X es, Give r or Dates.		If	Vas Decede Yes, speci	fy Cubar	, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh		
15-0	'2 hou "natu edical	Completed		edent's Education ighest grade comp	oleted)		16a. Deced (Give k	ind of work	done du	tion uring most	of worki	ng	1	nd of Business	Industry	
2121	vithin 7 liene. Ir than the M	Com	Elementary/Seconday (0-1	2) Colle	ege (1-4 or	5+)	life. DC	NOT use lerk	retired)				l .	or Vehi inistra		
nd	filed val Hyg d othe		17. Father's Name (First, Midd	le, Last)				LOIN		18. Mothe	er's Name	(First, Middle,				
Maryland	d Ment marke matic	욘			re, S	r.					Anna			Herchi		· ·
Z	d 2 sho alth an 27 is ir traui		19a. Informant's Name/Relati	, , , , , ,		ohtar								Town, State, Zi MD_2106	•	
Baltimore,	e 1 and of Hea If item or othe		20a. Method of Disposition 1 X Burial 2 Cremat		•	20b. Plac	ce of Dispos netery, crem	sition (Nam	e of			ate		cation - City or		
Itim	it. Pag irtment irtant: njury o		4 Donation 5 Oth	er (Specify)										n Burn		
Ba	permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic		21. Signature of Funeral Servi		\mathcal{I}_{M}	01121		Name and				-		eral & n_Burn:		
	Physician/		23a. Part 1. Enter the disease shock, or heart fallure. L Immediate Cause (Final disease or condition	e, or complice of ist only one lause	~		Do not enter	r the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approxin Interval E Onset an	nate Between
Y	Medical Examiner		resulting in death)	D		a consequer		- n	CLID	A :		, 9)			
		iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b		a consequer		17		NVI	-	1	MEDICAL EX	Va.		
Q (1)	ecuted and I-transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c	ue to (or as	a consequer	nce of):				W	ROVER BY I	WER			
, 09	ate be executed physician and the burial-transit	edical I	,	L d	,	,					FICATION	APPROVED BY				
6876	rtificate ling phy e as th	/Med	IF FEMALE:	20- 15	1					CEN						
Вох	idan: The law requires that the death certificate be execut certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 4	Live Birth	of pregnanc 2 Fetal d at time of dea	leath 3 🗌	Ectopic pr Other (spe					2	23d. Date of de Month	livery Day	Year
ls, P.O.	law requires that the nas been signed by the 2 should be detach	ed by P	Part II. Other significant con-	ditions contributing	g to death l	out not result	ing in the ur	nderlying ca	ause give	en in Part I				se contribute to		
Division of Vital Records,	he law req te has bee age 2 shor	Completed							_			24a. Was autor perfo		death?	topsy finding completion o	s available f cause of
<u>a</u>	ilan: T ertifica ctor, p	Se C	25. Was case referred to medi examiner?							ce of Deat	h <i>(Check</i>		2 A No	I L Yes	3 Z 🗆 NO	
Ę	Physic this ce al dire	: To Be	1 Yes 2 ☐ No 27. Manner of Death	Hospital:	1 Unpat	ient 2 EF	R/Outpatient			4 L Nu				Other (Spec	ify)	
o uc	Attending Physician: r death. ector: After this certific by the funeral director,	icate	1 Natural 5 Pe	ndina	(Month, Da	y, Year)	injury 1545	.	c. Injury work? 1 🔲 Y	aı ′es 2. 🛣		8d. Describe h		TREE		
visio	or Atte fter deg irector irector n by th	Certificate:	3 ☐ Suicide 6 ☐ Co	uld not be 28e.		ury - At home			office		- 1	28f. Location (S	Street and	Number or Ru		
Ö	spital o	cal	29a. Certifier 1 Certify	ring Physician: To		my knowled	lge death o	cured at t	he time	date and r		603 WES	J WAY	GIEN B		4061
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 ☐ Medic	al Examiner: On the ving Nurse Practic	ne basis of e	examination a	nd/or investi	gation, in m	y opinion	, death oc	curred at	the time, date a	and place,	and due to the	cause(s) and	manner stated.
	To 1 To 1		29b. Signature and title of cert	ifier)	ma		29c.	License	number	(1)		^	signed (Monti		
	^	-	30. Name and address of pers	on who completed	cause of c	leath (Item 23	3a) (Type. Pr	IVY	1175	141	46	1/	Deco	moin 16	201	O
	10		KENN M. JON	= 2	2 50	COTH G	proon		B	タレアハ	ORT	mo ?	2120	01		
	Stat	е	31. Date filed (Month, Day, Yea	Beren	32. Registr	ar's Signatur										

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		For State Registrar	State of Mary	_	artment of F <i>tificate of L</i>			giene Reg. No.	n I n	10260
Dhysisis	- /	Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath	Voor	3. Time of Death
Physicia Medic	al			arris			Decemb	T		3:50P ^M
Examin	er	4a. Facility Name (if not institution, give 706 Towering Oal	·		4b. City, Town, or Glen Bur	Location of Death			inty of Death e Arun	de1
Funeral Director		5. Social Security Number 6. Se 214-24-6662		yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Dec . 27	h		olace (State or Foreign try) MD
/land f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Loc	cation		_	_	1	0d. Inside City Limits
e Mary r 28a- notifie	Sirec	MD Anne Aru 10e. Street and Number	ınde1 G	len Burn	ie 10f. Zip Code					1 X Yes 2 No
with th 23a o sst be	Funeral Director	706 Towering Oal	s Court		21061			U.S.A.	of What Coun	itry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If	Vas Decedent of Hi	ispanic Origin? (Spe n, Mexican, Puerto Specify:	cifv Yes or No-	14. F	Race - Americ Black, White, e	
72 hour in "natu Medical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give k	lent's Usual Occupa kind of work done of ONOT use retired)	ation during most of worki	ing	16b. Kind o	f Business Inc	dustry
within 'giene.		Elementary/Seconday (0-12)	College (1-4 or 5+) 2	Cler	,			Acco	unting	
d be filed fental Hy rrked otf tic event	To Be	17. Father's Name (First, Middle, Last) Alfred Eckels				18. Mother's Name Nellie F		Maiden Surna	ame)	
d 2 should alth and N 27 is me or trauma		19a. Informant's Name/Relationship (Ty Mr Willie Harris			•	and Number or Rura				•
Page 1 an ent of He nt: If item ry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Specifi	Removal from State	0b. Place of Dispos cemetery, crem	sition (Name of natory or other place Haven Men		Date mber 010		on - City or To Burnie	
permit. F Departm Importa any injui		21. Signarture of Funeral Service Licens	70	22.	. Name and Addres	ss of Facility Sin	gleton	Funera	1 & Cr	-
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or long shock, or heart failure. List of or Immediate Cause (Final disease or condition resulting in death)	a	death. Do not ente	r the mode of dying		r respiratory arr	est,	l	Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last	c. Due to (or as a con							
0	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No g ☐ Unknown	23c. If yes, outcome of property of the control of	Fetal death 3	Ectopic pregnanc Other (specify)	у			Date of delive	ery Day Year
ires that signed t	۱۵	Part II. Other significant conditions co	ntributing to death but no	t resulting in the ur	nderlying cause giv	en in Part I.				ne cause of death?
: The law requ cate has beer ; page 2 shou	Completed						24a. Was a autop perfor 1 Yes	sy	b. Were autop prior to cor death? 1 ☐ Yes	osy findings available mpletion of cause of
sician s certifi	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatient	Othe	ace of Death <i>(Check</i> er: 4 Nursing Ho			241(0(6-1)	
ding Phy h. After this funeral d	ate: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Yea	28b. Time of	28c. Injury work	at	28d. Describe ho			
al or Atten s after deat I Director: d in by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp				28f. Location (Si City or Town		mber or Rural	Route Number,
n 24 hours n 24 hours n Funera	Medical	(Check 2 🖳 Medical Examin	ician: To the best of my k ner: On the basis of examin e Practioner: To the best	nation and/or investi	gation, in my opinio	n, death occurred at	the time, date ar	nd place, and	due to the cau	use(s) and manner stated
To th withii Comp		29b. Signature and title of certifier	noh	11	29c, License	number 0 / 7	78	29d. Date sig	ned (Month, E	Day, Year)
12		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type, Pr	rint)	#312,6	len Ru	Inie	MID	21061
State Registra		31. Date filed (Month, Day, Year) DEC 2 1 2010	32. Registrar's S			-,0/	icij isu	~///~	1 ()	
		/44.	1 7 1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 29cc30e Petyl DVR r69/10ed 24/24/14/19 I I Balth and Mental Hydienes and All Copies Are Legible.

		For State Registrar	•	antimenter He rtificate of De			Reg. No.	40261
Physici	an/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month Novembe	ath	3. Time of Death
Med Exami	cal	Paul Holland 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L		Novembe	4c. County of Dea	7:35 PMM
	iei	Prince George's Hospital		Cheverl				George's
Funera Director		1 ∑ M 2 □ F	(In yrs. last birthday) 62 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Dec_30	(Year) Co	thplace (State or Foreign untry) unk
and show at	ě	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation	-			10d. Inside City Limits
Maryla 28a-f	irect	Dc	Wash	ington				1 ☐ Yes 2X No
th the	Funeral Director	10e. Street and Number		10f. Zip Code	20000		10g. Citizen of What Co	
ems 2	nne	2425 26th Street NE 11. Marital Status unk 12. Was Decedent E	ver in U.S. 13. \	Was Decedent of Hisp If Yes, specify Cuban,	20032 panic Origin? (Spe	cify Yes or No-	US.	
rs after de ral", or it	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ 1 If Yes, Give Year or Dates.	io I	lf Yes, specify Cuban, 1 □ Yes 2 ሺ No		Rican, etc.)	Black, Whit	
DallilliOre, IMaryliand ZIZIO-UU3O permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5-	(Give	dent's Usual Occupati kind of work done du O NOT use retired)		_{ng} unk	16b. Kind of Business	Industry unk
d with dygien ther ther the	Be C	unk 17. Father's Name (First, Middle, Last)		1-	40 Mahada da Nasara	(First 8 4 int 11 in	14-1-4	1-
yiand Id be filed Mental Hy arked oth	일	17. Famer's Name (First, Wildow, Last)		unk	18. Mother's Name	e (First, Middle, i	waiden Surname)	unk
Midify 2 should th and h th and h trauma		19a. Informant's Name/Relationship (Type, Print)	1	-			; City or Town, State, Zi	
Te, I 1 and 2 1 Heatt item 2 other	1	Prince George's Hospital 20a. Method of Disposition	20b. Place of Dispo		, ,	heverly Date	90c. Location - City or	
Dalumore, bermit. Page 1 and Department of Hes mportant: If item nny injury or othe once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in stat	a	matory or other place)				
permit Depar Impor any in		21. Signature of Roseral Ace Sicenses ad Dire	ctor 8	Beltimore,	•		. Baltimore	Street
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.					est,	Approximate Interval Between Onset and Death
Physician/ Medica			ophageal c	ancer term	minal			Onset and Death
Examine		Sequentially list conditions, b.						
ted nsit	min	cause. Enter Underlying Cause (Disease or linjury	Consequence of j.				l	11
icate be executed in physician and street transit	Medical Examiner	that initiated events resulting in death) Last C. Due to (or as a	consequence of):					
icate k	ledic	d						
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of the pregnant at the pregnant	P Etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
quires that the signed by uid be detact	<u>\$</u>	Part II. Other significant conditions contributing to death bu	t not resulting in the u	underlying cause giver	n in Part I.		bacco use contribute to	the cause of death?
The law required the law required ate has been signated as been signated as the law and the law and the law are law and law and law are law ar	Completed					24a, Was a autop perfor 1 Yes	med? death?	topsy findings available completion of cause of
cian: cian:	Be	25. Was case referred to nedical examiner? Hospital:			e of Death (Check	only one)		
Physical direction	. To	1 Ves 2 No Nospital: 1 Inpatie 27. Man r of Death 28a. Date of injur	nt 2 ER/Outpatier / 28b. Time of		4 ☐ Nursing Ho		ence 6 Other (Spec	ify)
ending eath. or: Afte	ficat	1 ✓ Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	Year) injury	work?	es 2 🗆 No			
al or Attendin s after death. I Director: Aft d in by the fur	Certificate	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injurbuilding, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
le Hospita n 24 hours le Funera oleted fille	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of r	amination and/or invest	tigation, in my opinion,	, death occurred at	the time, date ar	nd place, and due to the	cause(s) and manner stated.
To th withii To th		29b. Signature and title of certifier	~~~	29c. License n	number		29d. Date signed (Monte	
		30. Name and address of person who completed cause of de		Print) ce Georges	Hospita	6128 1 Che	Landover F	Road ,MD 20785
Sta	ite ar	Die i lucii e i	's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2010 7:05 PMM Harry Hazlegrove December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Sept 7. 1959 1 🕅 M 2 🗆 F Months Maryland 220-76-6847 Yrs **Director** 51 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Sparks 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1341 E. Phoenix Road 21152 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, the Medical Examiner or Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white Specify: "natural", Completed 3 Widowed 4 Divorced unk 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Hazelgrove/spouse 1341 E. Phoenix Road Sparks, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Sigector Name and Address of Facility tate Anatomy Board 655 W. Baltimore Street altimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. W 22. Name and Address State Anato Baltimore, 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Starge usulte Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 2 No Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗵 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: A

completed filled in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Ivithin 2. only one) 29b. Signature and title of 29c. License number 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMAR ARATHI 31. Date filed (Month, Day, Year)
DEC 21 State Registrar's Signato Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dec. 18, 2010 Physician/ 1:45 P William E. Hill Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Seasons Hospice Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, lav 31 **X**□ M 2 □ F Year Country)
MD Months Days Hours Min. 216 14 0562 90 **Director** May Usual Residence of Decedent or 28a-f shov 10a. State 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 630 Perkins St. 21201 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Laborer Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Samuel Hill Daisy Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Hill (wife) 630 Perkins St. Balto, City, Md. 21201 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Dec.28,2010 Baltimore,Md. Donation 5 C Other (Specify) Agnature of Funeral Service Licensee Calvin B. Scruggs Funeral Home 23a. Part 1. Enter the disease, or complications that caused be shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final MKINSONS Physician/ disease or condition resulting in death) Medical Due to (or a a con- guence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other byputient hispex. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation To the Hospital or Atter within 24 hours after dea To the Funeral Director completed filled in by th Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Dark

STITH

TOALTIMOLE MI)

TE 203

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

2835

2. Registrar's Signature

MEDILITI

31. Date filed (Month, Day

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0815 AM Yevalta Ubdulia 46110WW DECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Days Min ^c∘**Ph**∜lippines 09-05-7841 214-64-8889 69 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3300 Echodale Avenue 21214 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher/Counselor State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even once. Ith and Mental H
27 is marked of
raumatic ever ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21214 Mr. James P. Holloway - Husband 3300 Echodale Avenue 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillton Service Corp. 12-21-2010 Towson, Maryland 21. Signature of Funeral Semine dic 5305 Harford Road 22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ JULTI- ORGAN FAILURE WEEKS disease or condition Medical resulting in death) Examiner TUBERCU LOSIS IN FECTION Mouths SSEMINATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARDIAC ARREST 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? POXIC BRAIN INJURY 24a Was an autopsy performed Yes 2 2 certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) æ examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital: 2 No 1 ♣ npatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1.X Natural 5 Pending Investigation Accident filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier î 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year) RES-000 2010 DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALTIMORE GRAHAM MD0 4940 LAUREN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 Perater of Warvian 03 began ment of Health and Mental Hygiene U U

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Vear Month Day **Physician** Stanley Huber 15 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner pital Baltimore 05 Franklin Square 1+05
5. Social Security Number 6. Sex ar | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Months Davs Hours Min. 68 May 6,1942 Maryland Director 217-38-4004 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ∏Yes 2X No Director Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21220 United States 720 Kingston Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 196 XXYes EE No If Yes, Give 196 14. Race - American Indian, 11. Marital Status 1961-1965 Black, White, etc. 1 Never Married 2 Married 5-0036 1 ☐Yes 2 🛣 No Specify. Specify: Completed by It Yes, Give Year or Dates: 3 Widowed 4 Divorced White "natural" 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Security Officer G.E.D. Security marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Louise Fauver John Fred Huber ို Pages 1 and 2 should nent of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Leila M. Huber (Wife) 720 Kingston Road Middle River, MD item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12/18/2010 Department of Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland Sacred Ht. of Jesus Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 21. Signature of Funeral Service Licensee Approximate interval Between Onset and Death 233 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Failure a. 1-1005T disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ardiomy Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Physician/Medical Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the burial-tran Box 68760, physician Stage attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate I 1 Yes 2 No : After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Res 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Devada+ta filed (Month, Day, Year) C 2 1 2010 Sarwate 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

Registra

OCME

31. Date filed (Month, Day, Year)
DEC 2 1 201

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

,		1- For State Registrar	•	ertificate of Dea			2 U 1 U g. No.	1 40201
Physicia	n/	Decedent's Name (First, Middle,Last)				2. Date of Deat	h	3. Time of Death
ledical Examin	ıer	Gary Lee Jones				Month December	17, 2010	1214 hrs
A many		4a. Facility Name (if not institution, give street and number	r)		, Town, or Location of De	eath	4c. County of Deat	
		9109 Bengal Road		Ran	dallstown		Baltimore Co	unty
Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs.		nder 1 Year If Under 24		h(MM/DD/YYYY) 9. Bi Forei	
Director	-	214-62-2898 1xxm 2 F	54	Yrs. Mon	iths Days Hours	Min. 3/31	/1956	ountry) MD
	ł	Usual Residence of Decedent				-, -,		
any	ı	10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
ikow Ee	ايا	MD Baltimore		Randallstov	wn			1 Yes 2XX No
Maryland 28a-f show d at once.	윙	10e. Street and Number		10f. Z	ip Code	10	g. Citizen of What Cou	intry?
he M.	Director	Olli Papasi Dd			21133	i	TICA	
s 23a		9111 Bengal Rd. 11. Marital Status 12. Was Deceder	nt Ever in U	J.S. 13. Was Dece	dent of Hispanic Origin?	(Specify Yes or No-	USA 14. Race - Amer	ican Indian, Black,
eath v	Funeral	1 Never Married 2 Married Armed Forces	s? 2 X No		cify Cuban, Mexican, Pu		White, etc.	
iter d		1 Yes 3 Widowed 4 Divorced If Yes, Give Year	· · No	1 Yes	2XX No specify:		Specify: Wh	ite
urs af tural	흔	15. Decedent's Education (Specify only highest grade co	mpleted)		al Occupation (Give kind	of work done	16b. Kind of Business/	
2 ho	<u>ڇ</u>	Elementary/Secondary (0-12) College (1-4 or	5+)	during most of w	orking life. DO NOT use	retired)		
No36 within 72 iene. cr than Medical	힑	12		Disable	ed		n/a	
5-0036 led within 72 Hygiene. other than	Completed	17. Father's Name (First, Middle, Last)		L	18.Mother's Na	ame (First, Middle, M		
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygene. marked other than "natural", or items 23a or 28a-f shu cevent, the Medical Examiner must be notified at once	B	Loran Jones			Anna	Miller		
	ပ္	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Addres	ss (Street and Number	or Rural Route Numi	per, City or Town, State	e, Zip Code)
s, MD 21 and 2 should lealth and Me ten 27 is ma traumatic cv		Angela Jones/Wife			engal Rd., E	Randallsto	own, MD 211	.33
Te, 1 and 1 heal		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from S		Place of Disposition (Na crematory or other place		Date	20c. Location - City or	Town, State
MOI ages ant of att. I		Burial 2 X Cremation 3 Removal from S 4 Donation 5 Other Specify:	tate		rematory 12	2/19/2010	Winfield	MD
Baltimore, MD 2: permit. Pages 1 and 2 should Department of Health and M Important: If item 27 is us injury or other traumatic	ŀ	21. Signature of Funeral Service License		22 Name an	d Address of Facility Ler-Queen Fu	2/15/2010	winiteld,	TID D
ij F pe B	-	Mulle (Miller		1212	W. Old Libe	ineral Hon	ne & Cremat	ory, P.A.
Physician		3a. Paryl. Enter the disease, or complications that cause	d the death	n. Do not enter the mode	of dying, such as cardia	ac or respiratory arre	st, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Contact Gunsh	ot Wou	nd of Head				Between Onset and Death
kaminer	-	or condition resulting in death) Due to (or as a con-						
	.	Sequentially list conditions, b.						
	<u> </u>	if any, leading to immediate Due to (or as a con-	equence o	of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last	sequence (of):				
uted Id ansit		d.	·	•				
of Vital Records, P.O. Box 68760, iog Physiciso: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and huneral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED			-			
ords, P.O. Box 68760, w requires that the death certificate be is been signed by the attending physici should be detached for use as the built is the control of the detached for the street of the built is the signed by the attending physici should be detached for use as the built is the signed of the signed o	ş	IF FEMALE: 23c. If yes, outco	me of prec	inancy			23d. Date of deliver	,
787 rtifica ing p as th		23b. Was decedent pregnant in the past 12 months?		2 Fetal death	h 3 Ectopic pre	gnancy		Day Year
Box 687 e death certific the attending I ed for use as th	Physician/	4 Pregnant a	t time of de	eath 5 Other (Sp	ecify)		1	
the z	ڇ					Loo. Bitt.		(4-4-2
that the ted by detacl	Ş	Part II. Other significant conditions contributing to dea	th but not r	esulting in the underlyin	ng cause given in Part I.		eacco use contribute to 2 ✓ No 3 ☐ Prot	
uires In sign		-				- 🗀		
» req						24a. Was ai autops		topsy findings available completion of cause of
he la ate ha age 2	Completed					perform 1 ✓ Yes 2		es 2 No
Triffic	ပို	25. Was case referred to medical			26.Place of Death (Che	ck only one)		
Vita ysicia direc	e e	examiner? 1 Yes 2 No Hospital: 1 Inpati	ent 2	ER/Outpatient 3	DOA Other Nu	rsing Home 5 R	Residence 6 🗸 Other	: Scene
Division of Vital Records, P.O tal or Atteodiog Physiciao: The law requires that ts after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detacted.	إج	27. Manner of Death 28a, Date of Inc.	ury	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	ow injury occurred	
codic ath. the fu	흵	1 Natural 5 Pending FOUND: Day, Dec 17, 201		FOUND: 1205 hrs	1 Yes 2 ✔ No	Subject shot	seif	
r Att r Att ter de rirect n by 1	<u>≅</u>	2 Accident		ome, farm, street, factor	y, office building, etc.		reet and Number or Ru	ral Route Number, City
Lits af	Certification: To	4 Homicide determined (Specify) Of	her (yan	d)		or Town, Sta 9109 Bengal R	ate) oad , Randallstown,	MD
		29a. Certifier 1 Certifying Physician: To the best of r	ny knowled	lge, death occurred at th	ne time, date and place, a	and due to the cause	(s) and manner as state	ed.
thin 2	Medical	one) 2 Medical Examiner: On the basis of exa	amination a					
F. 2 F. 8	影	and manner stated 29b. Signature and title of certifier		29	9c. License number	I	29d. Date signed (Mo	nth, Day, Year)
		my his. he	1>		O.C.M.E.		December 18, 20	010
	ŀ	30. Name and address of person who completed cause of	death (Iten	n 23a)				
		Ling Li, MD Assistant Medical Examine			timore, MD 21201			
Sta	te	31. Date filed (Month, Day, Year) 32. Registr	ar's Signati	ure			· · ·	
Ponietr		111-1 9 1 /1111 //page 2.	LA Q	L.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day :15 Physician/ 2010 Janey CYNTHIA December Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Batti jeasons Huspice e Northwest Hospital andalistan If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Hours Min Country) 1 M 2 F 2.78.320 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State ms 23a or 28a-f sho must be notified at **Funeral Director** Owings 1 Yes 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2117 Circle 1 and 2 should be filed within 72 hours after death with in the lath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a ance 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Black 1 Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)

Office Man ager PB Health Elementary/Seconday (0-12) College (1-4 or 5+) years veals 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Thornton ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tahoe Cirdo Apt. B Dings Mills, MD 2117 Dallitter Karen Janev or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Windsor Mill, MD 2010 Memorial Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Valighm C. Greene Funeral Services 21. Signature of Funeral Service Licensee permit. once. any Road Kandallston MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause Kinal disease or condition

End Stage Lenal Disease

in the death. Approximate Interval Between Onset and Death Physician/ resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ng physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 L g ☐ Unknown page 2 should be detached g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 4 Nursing Home 5 Residence 6 Other Specify Other: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: injury 1 🗹 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MSRaj apalne MID D0057465 (2/17/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smin AV 5-7=3- Baltimore, MD. 21209 N.S. Rajapa KER MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please	Type or Print in Black Indelible Ink. Ensure All Copies Are State of Maryland / Department of Health and Mental Hygiene	Legible. 👝 👝	0	P.	\cap	17	6
	State of Maryland / Department of Health and Mental Hygiene	201	U			lan !	0

		1- For State Registrar	Cei	rtificate of L	Death		Re	g. No.				
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, L.	Mante Joy	ner			2. Date of Death Month December	Day Year 11, 2010	3. Time of Death 0835 hrs			
		4a. Facility Name (if not institution, g Prince George's Hospita			City, Town, or L C heverly	ocation of Deat,	h	4c. County of Dea				
Funeral			Sex 7. Age (In yrs. I		If Under 1 Year	If Under 24Hr	s. 8. Date of Birt		Birthplace (State or Foreign			
Director		578-23-0626 1 Usual Residence of Decedent	2 F S	Yrs.	Months Days	Hours Min	06-16	1000	ashington, DC			
. any		10a. State 10b. County	10c. City,	, Town or Location					10d. Inside City Limits			
faryland 28a-f show Lat once.	ē	MD Prince	beorge's Lar	ndover					1 Yes 2 No			
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	1 0	1	Of. Zip Code		10	g. Citizen of What Co	ountry?			
vith the s 23a c		11. Marital Status	12. Was Decedent Ever in U.	.S. 13. Was D	2017 ecedent of Hisp	.5 panic Origin? (S	pecify Yes or No-	14. Race - Amo	erican Indian, Black,			
leath v	uneral	1 Never Married 2 Marrie	A T O		specify Cuban,			White, etc.				
after c	by F		d If Yes, Give Year or Dates:		es 2 No			Specify: B	1acK			
2 hours		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed) College (1-4 or 5+)	16a. Decedent's during most	Usual Occupation of working life. I			16b, Kind of Busines	s/industry			
5-0036 led within 72 hours ar Hygiene. tother than "natural the Medical Examin	Completed	11th		Stu	lent							
Dre, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she her traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Las	t)		1:	8.Mother's Nam	e (First, Middle, M	laiden Surname)				
ore, MD 2121 is 1 and 2 should be fill of Health and Mental I If iten 27 is marked	To Be	19a. Informant's Name/Relationship	Type, Print)	19b. Mailing A	dress (Street	and Number or	Rural Route Num	ber, City or Town, Sta	ite, Zip Code)			
and 2 should realth and N item 27 is m traumatic		Renee Joyner			ewton	St. NU	V Washin		20010			
15 E E		20a. Method of Disposition 1 Deurial 2 Cremation 3		Place of Dispositio crematory or other		etery, 12	Date / 23/2010	Oc. Location - City of 7101 She	or Town, State			
Pag Pag ment tant:		4 Denation 5 Other Specia			larmon e and Address		120110	Engo, Md	20792			
Balti permit. Departr Import injury		21. ignat e o uneral Service lice	Masen	ZZ. IVali	and Address	osm Fig	end Service	1 1 10 2 1	nedy st. W			
Physician		23a. Part I Enterine ise on or failure. List only the use on		. Do not enter the	mode of dying, s	uch as cardiac			Approximate Interval Between Onset and			
`∤Medical ≟xaminer	Multiple Gunshot Wounds											
		Sequentially list conditions,	Due to (or as a consequence o	1):								
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	f):								
T it	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f):								
xecuted n and l - transit		UNPENDED	XAMENDED									
'60, sate be er physician he burial	Medical	IF FEMALE:	XAMENDED, per Fh	G910 12	/21/10	TT		23d. Date of delive	ery			
687 ertifica ding p	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of de	2 Fetal		Ectopic pregn	ancy	Month	Day Year			
Box 68's death certifine attending ed for use as	Physician/	1 Yes 2 No 9 Unknow		oath 5 Other	(Specify)							
P.O. Ess that the d	by Ph	Part II. Other significant conditions	contributing to death but not re	esulting in the und	erlying cause giv	ven in Part I.		pacco use contribute t				
S, P.C quires that en signed l							1 Yes		obably 4 Unknown			
Records, The law requir ficate has been si	Completed						autops	sy prior to	completion of cause of			
tal Rec		25. Was case referred to medical		_	26 Place	of Death (Check	1 Yes 2	No 1 🗸	Yes 2 No			
of Vital ng Physician ther this certi	To Be		Hospital: 1 / Inpatient 2	ER/Outpatient 3		ther =		Residence 6 Oth	er:			
ing Ph After t funeral		27. Manner of Death	28a. Date of Injury (Month, Day, Year) Dec 9, 2010	28b. Time of Injur	' 1 _ `		1	ow injury occurred by police returni	ing fire			
Division tal or Attendi rs after death. al Director: A	catic	2 Accident 5 Pending Investiga				es 2 V No			Rural Route Number, City			
Divis pital or At ours after d ceral Direc filled in by	Certification:	3 Suicide 6 Could no determin	t be		actory, office bu	ilding, etc.	or Town, St					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transi		29a. Certifier 1 Certifying Physi	cian: To the best of my knowled	ge, death occurred	at the time, date	e and place, and	due to the cause	e(s) and manner as sta	ated.			
To the Hos within 24 h To the Fun completely	Medical		er: On the basis of examination all and manner stated.	nd/or investigation			at the time, date a					
	2	29b. Signature and title of certifia	9/1/190		29c. License O.C.M			29d. Date signed (MDecember 12, 2				
		30. Name and address of person who	completed cause of death (Item	23a)	1							
			Assistant Medical Examir	ner 111 Per	n Street, Ba	altimore, MD	21201					
St Regist	~~	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	and					3			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ T_{M} Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** UMEWOO MO Date of billing 7. Age (In yrs. last birthday)

LLQ

Yrs. 9. Bjrthplace (State or Foreign Gountry) If Under 24 Hrs. **Funeral** 6. Sex If Under 1 Year 8. Date of Birth 990 Days 1 □ M 2 🗗 F Hours Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sister 19a. Informant's N. me/Relationship (Type, Print) oute Number, City or Town, State, 19b. Mailing Address (Street and Number or Rur 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 27 12010 4 Donation 5 Other (Specify) T Funeral Service Lice 22. Name and Address of Facility
JOSEPH L. RUSS
22-72-W. NORTH Signate Funeral Home, JU 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE as been signed by the attendin 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy page performed? death? 2 No Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Hospital 2 TNo Other ပ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation the ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State, 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31464 MD 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 EUTAW BOUTMORE MD 2120, TZ Frite 308 1 MH2 N.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

21

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Olale	i wai yian		tificate of L		u Mentai riy	Reg. No	711111	402	271
	Physicia		1. Decedent's Name (First, Mic Marsella Patr						2. Date of Do		y 201 0	3. Time of 00:40	Death aM
-	Medic Examin		4a. Facility Name (If not institut Southern Mar		ber)		4b. City, Town, or	r Location of D			County of Death		CIA
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)	Clinton If Under 1 Year	If Under 24 H	Hrs. 8. Date of Bi	rth	Prince G	orge	r Foreian
	Director		214-11-8241 Usual Residence of Decedent	1 □ M 2 🛣 F		41 Yrs.	Months Days	Hours N	Min. (Month, D 6-26-	969 (Sear)	Cou	ntry) MD	
	land show dat	tor	10a. State 10b. Cour	nty	10c. Cit	y, Town or Lo	cation					10d. Inside Cit	y Limits
	e Mary r 28a-1 notifie	Jirec	MD I	rince George	I	orestvi						1 🗌 Yes	2 XNo
	h with the ns 23a ou nust be	Funeral Director	6139 N.Hil-Mar C				10f. Zip Code 20747				izen of What Cou USA	intry?	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 X Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2	Armed Fo 1 Yes If Yes, Giv Year or Da	2 🔼 No e	1	☐ Yes 2 🕅 No	Specify:	? (Specify Yes or No- uerto Rican, etc.)		14. Race - Amer Black, White Specify: Aft		rican
215-	in 72 ho e. ian ''na' Medic	Completed	(Specify only high	dent's Education ghest grade completed) College (1-	4 or 5+)	(Give I	ent's Usual Occup ind of work done o NOT use retired)	ation during most of t	working	16b. Ki	ind of Business I	ndustry	
121	d within tygiene. ther than nt, the N	Be Co	12th 17. Father's Name (First, Middle			Child	Care				pring Chri	stian Ac	adeny
land	uld be filed Mental Hy narked oth	10	Joe Kerry Johnson					Deborar	Name (First, Middle n A lle n	, Maiden S	Surname)		
Jan	should Nand Nand Nand Nand Nand Nand Nand Nan	10	19a. Informant's Name/Relatio			The second			Rural Route Numbe		Town, State, Zip	Code)	
re,	I and 2 I Healtl Item 2 other t		Joe Johnson/ Fath 20a. Method of Disposition		20b. P	lace of Disno	sition (Name of		njemoy, MD 2		ocation - City or T	own. State	
Baltimore,	ment o tant: If ury or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Othe	on 3 Removal from (Specify)	State Arb	utus Mem	orial Park	12	2-20-2010	Artu	tus, MD		
Balt	permit Depart Import any inj		21. Signature of Funeral S, rvic	Licensee/ W.W.U.	ledie	²² 220	Name and Addres Liberty F	ss of Facility W Road, Ran	ylie Funco dallstown,	11 Ham MD 21	e P.A. of 133	Ralto. C	D.
	Ph_sician/ _ Medical	25 N	23a. Part / Enter the disease, sheck, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	at only one cause on ea	ace	ita	r the mode of dying	g, such as card	diac or respiratory at	rrest,		Approximate Interval Betw Onset and D	/een
-	Examiner			Lue to (or as a consequ	ience of):							
	ed ssit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequ	ience oŋ.							
	cate be executed physician and the burial-transit	l Exa	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):							
8760	ificate be ng physic as the bu	Medical		d									
Box 6	ath cert attendir or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1	23c. If yes, out 1	iant at time of u	ncy I death 3 🗆 leath 5 🗆	Ectopic pregnanc Other (specify)	у			23d. Date of deliv Month	*	ear
, P.O.	es that the des signed by the a be detached	þ	Part II. Other significant cond	tions contributing to de	ath but not resi	ulting in the u	nderlying cause giv	en in Part I.		_	se contribute to t		
of Vital Records,	requires been signatures	Completed	3 15	•			- 67 min - 77 M Z-16 - 1		1		No 3 ☐ Pro	bably 4 🗆 U	
Rec	The law cate has page 2	Somp							 auto perfe 		prior to co	mpletion of ca	use of
ta	Physician: The r this certificate ral director, pag	Be	25. Was case referred to medic examiner? 1 X Yes 2 ☐ No	Hospital:			Othe	ace of Death (C	Check only one)				
n of V	ding Phys h. After this funeral di	ate: To	27. Manner of Death 1 Natural 5 Pen	28a. Date of (Mont	npatient 2 of injury of, Day, Year)	ER/Outpatien 28b. Time of injury	28c. Injury	4 ∐ Nursin	g Home 5 Resi			/)	
Division	I or Attendii after death. Director; Af d in by the fu	Certificate:	3 Suicide 6 Cou	minod 28e. Place	of Injury - At hor g, etc. (Specify)	me, farm, stre	et, factory, office	165 2 110	28f. Location (S City or Tox		l Number or Rura	l Route Numbe	er,
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 \(\subseteq \textbf{Medica} \)	ng Physician: To the be I Examiner: On the basi ng Nurse Practioner: T	s of examination	and/or investi	gation, in my opinio	n, death occurr	ed at the time, date a	and place,	and due to the ca	use(s) and man	ner stated.
•	To the within 2 To the comple	2	29b. Signature and title of certif		m. 1	omeuge, u	29c. License				e signed (Month,		
			30. Name and address of person	n who completed cause	of death (Item	23a) (Type, Pi	int)	<u> </u>		/	-16	00 / 0	
	Stat	_	31. Date filed (Month, Day, Year,	32. Re	gistrar's Signati	1750 ure	LSurrat	tsPd.	Suite 2	05(Unton,	md 20	735
	Registra	_	DEC 2 1 2010		A A	nikel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JONES RALPH 2103 M 2010 DECEMBER 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns HOOKINS Baltimore Cl der 1 Year | If Under 24 Hrs. HOCOLTA 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 🗓 M 2 🗆 F Months Days Hours Min Yrs 61 **Director** 224-70-4221 MAR. 4 1949 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural;" or items 23a or 28a-f show any injury or other traumatic event, the Medical Extrainer mast no rolling as 1 X Yes 2 □ No Directo MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3844 SINCLAIR LANE 21213 Funeral U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: BLACK þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RENAISSANCE HOTEL 12th grade KITCHEN AIDE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDWARD JONES ဂ္ ROSA BELLE SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3844 Sinclair Ln., Baltimore, Maryland 21213 Shavonia Jones/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 12-18-2010 BALTIMORE, MARYLAND Signature of Fungral Service Licensee william C Brown COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as e consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown icate has been si , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed Yes 2 2 No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 No 1 ☐ Yes Certification: To Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After th filled in by the funeral 27 Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Natural 2 Accident (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a. Certifier 1 Certifying Physiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMPTP 12 2010 ress of person who completed cause of death (Item 23a) (Type, Print) FINER 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

onn C. Jonnsoi		51a 1- For State Registrar	te of Maryland		rtificate of		id Me	iai riygiene	Reg. No.	2010	40213
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,	•					2. Date of D Month	eath Day Der 15, 2	Year	3. Time of Death 0151 hrs
HUICAI EXAIIII	ner	John C. Joh 4a. Facility Name (if not institution,	nson , Jr			lb. City, Town, o	r Location o			County of Death	
		Shady Grove Adventist	Hospital			Rockville				ontgomery	
Funeral Director		217–30–1153		ge (In yrs. I	ast birthday) Yrs.	If Under 1 Ye Months Day		Min.	Birth(MM/E	1930 Co	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on					10d. Inside City Limits
	'n	Maryland Frede:	rick	Mot	ınt Airy	7					1 Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number				10f. Zip Code 21771				en of What Cour	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4236 Bartholows	12. Was Deceder			s Decedent of H		in? (Specify Yes or		14. Race - Ameri	can Indian, Black,
r death	Funeral	1 Never Married 2 Marr	1 X Yes	2 No		_		Puerto Rican, etc.)		White, etc.	
rs after ural", miner	ğ	3 Widowed 4 Divor	ced If Yes, Give Year or Dates:			Yes 2 X No		kind of work done		Specify: Whit ind of Business/I	
72 hou n "nat	Completed	Elementary/Secondary (0-12)	College (1-4 o			ost of working life			.,		·
0036 within iene.	m d		2		Draft	sman				ASA	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, L. John C. Johnson	•				18.Mother Heler	s Name (First, Middl n. Rav	e, Maiden S	Surname)	
212 ould be 1 Ment 1 mark ic ever	TO B	19a. Informant's Name/Relationship				• • •	et and N um	ber or Rural Route N			
MD and 2 sho alth and 27 is		Jane M. Lapp /	Daughter	100		Cutsail		re, Damaso		laryland	
Baltimore, permit. Pages 1 at Department of He. Important: If ite		1 X Burial 2 Cremation	3 Removal from S	State	crematory or oth	er place)		December 20	,	-	
Itim it. Pag artment ortunt:		4 Donation 5 Other Special Signature of Funeral Service Li		Par		orial Park ame and Addres		2010		kville, Ma	
Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep		Cnlc C		M015	300	West Mont	gomery.	uneral Home Avenue, Ro	ckvil	le, Mary	land 20850
Physician IV edical		23a. Part f. Enter the disease, or co failure. List only one cause or	n each line.					ardiac or respiratory	arrest, shoo	ck, or heart	Approximate Interval Between Onset and
ixaminer	Ī	Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive A			ovascular Di	sease				Death
		Sequentially list conditions,	b.	004401100	·/·						
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence o	f):						
uted d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence o	f):						
50, te be executed nysician and burial - transit	ledical	UNPENDED	AMENDED								
Box 68760, : death certificate be the attending physic d for use as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	ome of preg		al death 3	Ectonic	pregnancy		Date of delivery	ay Year
Box 6876 Re death certificate The attending phy red for use as the l	iciar	past 12 months?	4 Pregnant	at time of de	oth -	al death 3 ner (Specify)	Letopic	pregnancy		WOTH!	ay rou
. Bo he deat y the at hed for	Physician/N	Part II. Other significant condition	9 OHKHOWH	th but not s	oculting in the u	ndorlying cause	given in Par	d 23e Di	t tobacco u	se contribute to	the cause of death?
i, P.O.	ð	Parkinsons Disease	ne continuating to dea	itir but not n	esalting in the d	inderlying cause	giverimia				ably 4 🗸 Unknown
rds, require been si hould b	Completed							24a. W.	as an topsy		opsy findings available ompletion of cause of
of Vital Records, ag Physician: The law requir wher this certificate has been si meral director, page 2 should t	dmo		-					pe	rformed? s 2 No	death?	
Vital Rec ysician: The his certificate director, page	S B	25. Was case referred to medical examiner?				26.Plac		Check only one)			brancol .
f Vit	2	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpat		ER/Outpatient 28b. Time of Ir		ury at Work?	Nursing Home 5 28d. Descrit			
on of nding Pl th. r: After re funera	ion:	1 ✓ Natural 5 Pendin	(Month, Day	Year)	200. Tille of II		Yes 2		c now injui	y cocurred	
Division Isl or Attendi Isl or Attendi Isl affer death. Isl Director: //	ertification:	2 Accident Investig 3 Suicide 6 Could	28e Place of	Injury - At h	ome, farm, stree	t, factory, office	building, etc			d Number or Ru	ral Route Number, City
Divi	Cert	4 Homicide determ						or Towr	, state)		
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	cal		sician: To the best of oner:On the basis of ex								
To t with To t	Medica	29b. Signature and title of certifier	and manner stated			29c. Licen				ate signed (Mor	
		What Box	A MA	5		O.C.	M.E.		Dece	ember 15, 20	10
5+1		30. Name and address of person w			•	0: . :	D = 141···	MD 04004			
<i>)</i> \		Melissa Brassell, MD	Assistant Medica			enn Street, I	Baltimore	e, MD 21201			
St Regis	ate	31. Date filed (Month, Day, Year)	A SZ. Registi	To Gigila	arkes						

OGME

Baltimore. Maryland 21215-0036 Division of Vital Records. P.O. Box 68760

		Please	Type or Print in	Black In	delible Ink. Ens	sure All Copie	es Are L	.egible).
	-	For State Registrar	State of Marylar		rtment of Health tificate of Death	and Mental H	ygiene Reg. No.	010	40274
Discosision	/	1. Decedent's Name (First, Middle, Las	t)			2. Date of E Month		Year	3. Time of Death
Physicia Medio		Lowell Thomas K				12/	17/201	0	8:22 A ^M
Examin	er	4a. Facility Name (if not institution, give			4b. City, Town, or Location	of Death		unty of De	
<u> </u>		Gilchrist Hospi 5. Social Security Number 6. Se		land to last along	Towson If Under 1 Year If Under	24 Hrs. Lo. D. L		Balti	
Funeral Director			7. Age (<i>In yrs.</i>	Yrs.	Months Days Hours		71934		irthplace (State or Foreign ountry) VA
nd how at	ř	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Loc	ation				10d. Inside City Limits
laryfa 3a-f s iffed	Director	MD Carro	11	Woodb	ine				1 🗆 Yes 2 🌁 No
the M or 28 e not	흐	10e. Street and Number		WOOGD	10f. Zip Code		10g. Citizer	n of What C	Country?
with i	eral	7225 Woodbine R	d.		21797			USA	
leath items	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		/as Decedent of Hispanic Ori Yes, specify Cuban, Mexican	igin? (Specify Yes or No	D- 14.		erican Indian,
be filed within 72 hours after death with the Maryland ental Hygiene. Wed other than "natural", or items 23a or 28a-f show the word, the Medical Examiner must be notified at	l by	1 Never Married 2 Married	1 K Yes 2 □ No		☐ Yes 2 🛣 No Specify.		Spi	Black, Wh	
ours a	etec	3 Widowed 4 □ Divorced 15. Decedent's E	Year or Dates. unkn		ent's Usual Occupation			, W	hite
an "ng Medic	Completed	(Specify only highest gra	de completed)	(Give k	ent's Osdai Occupation ind of work done during mos) NOT use retired)	t of working	16b. Kind	of Busines	s Industry
within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5+)	1	ree Surgeon		Knigh	t's T	ree Service
filed al Hyg	Be	17. Father's Name (First, Middle, Last)			18. Moth	er's Name (First, Middl	e, Maiden Sur	name)	
ld be Menta arke	욘	Everett Knight	<u></u>		_	Cigourney	Morris		
shou and is m		19a. Informant's Name/Relationship (T)			g Address (Street and Numb				Zip Code)
and 2 Health em 27 ther tu		Craig Knight/So			4 Fox Circle,				
ge 1 a it of F if ite or ot		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐	Removal from State		atory or other place)	Date		tion - City o	or Town, State
it. Pag rtmer rtant ritant njury		4 Donation 5 Other (Specif			1 Crematory			field	
permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiener Important: If item 27 is marked other than "any injury or other traumatic event, the Meconce."		21. Signature of Funeral Service Licens	Chille	1 1	Name and Address of Facili Burrier-Queen 212 W. Old Li	^{ly} Funeral H berty Rd	ome & Winfi	Crema eld.	tory, P.A. MD 21784
		23a. Par 1. Enter the disease, or composite ck, or heart failure. List only of	olications at caused the dea						Approximate Interval Between
Physician	1	Immed ate vause (Final diseas a or condition	a Luug	('a	10 Ce 5			ii ii	Onset and Death
Medical Examiner		resulting in death)	Due to (or as a son eq	uence of):					
355	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):				_	
ecuted and I-transit	xamine	cause. Enter Underlying							
execu an and rial-tra	ш	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
ath certificate be exattending physician for use as the burial	Physician/Medical		d						
rtifica ling pl	/We	IF FEMALE:	00 - 15						
ath ce attend for us	ian	in the past 12 months?	23c. If yes, outcome of pregnation 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of	aldeath 3 🗌	Ectopic pregnancy Other (specify)		230	d. Date of d Month	elivery Day Year
the a	lysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	g Unknown	death 5	Other (specify)				
hat the		Part II. Other significant conditions co	ontributing to death but not re-	sulting in the ur	nderlying cause given in Part	I. 23e. Dio	tobacco use	contribute	to the cause of death?
uires 1 n sign lid be	ed by					1 2	Yes 2 🗆	No 3 🗆	Probably 4 🗆 Unknown
v requ	Completed					24a. Wa		4b. Were a	utopsy findings available
he lav te has	mo						opsy formed? s 2 No	death?	es 2 No
ian: T irtifica ctor, p		25. Was case referred to medical examiner?		-1517-	26. Place of Dea	th (Check only one)	223110		
hysic nis ce I direc	일	1 Yes 2 X No	Hospital: 1 🗀 Inpatient 2 🗆	ER/Outpatient	t 3 ☐ DOA Other: 4 ☐ N	ursing Home 5 🗀 Re	sidence 6	Other (Spe	ecity) Hospice
ding Pl th. After tl funera	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at work? M 1 Yes 2	.	how injury oc	curred	(
r Atten er deal rector: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined				28f. Location	(Street and No	umber or R	ural Route Number,
ital o ral Di									
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2 Medical Exami	ician: To the best of my knowner: On the basis of examination	on and/or investi	gation, in my opinion, death o	ccurred at the time, date	and place, an	d due to the	e cause(s) and manner stated.
o the orthon of the comple	Σ	only one) 3 L Cectifying Nurs 29b. Signature and title of certifier	e Practioner: To the best of m	iy knowleage, d	29c. License number	and place, and due to	1		is stated. hth, Day, Year)
F S F O		A CARS	M.D		D00712	87	12	17/1	۵
	- 1		111.7		1200119	0		1,11	19

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (f not institution, give street and rumber) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** inston 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 1 / 18 / 1923 Country) UKRAINE Director 217-33-7046 87 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Completed by Funeral Director 1 X Yes 2 □ No MD N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5900 PARK HEIGHTS AVENUE, #611 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: 3 XWIdowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) **PHYSICIAN** MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည KONEVSKIY ELIZABETH DAVID 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8615 STEVENSON ROAD, STEVENSON, MD YELENA LUBMAN/GRANDDAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State HAR SINAI CEMETERY 12/19/2010 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ™ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha performed' 1 Tyes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Lettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signatu title of certifier

State Registrar ss of person who completed cause of death (Item 23a) (Type, Print)

200 Memorial
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 350 Lewis Suzanne Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death morce If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year May 26 1 Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Country) Indiana **Director** 262-56-5759 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d Inside City Limits 1 Yes 2 X No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10696 Rain Dream Hill 21044 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify: 3 Divorced 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Kuhn Martha Burkett and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a George T. Lewis/husband 10696 Rain Dream Hill Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ō 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Journey Crematory 12/21/2010 Woodbine, Maryland 21. Sign e of Funeral Service Liec Going Home Cremation Service P.O. Box 784 home anta R M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner umonia Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury use as the burial-transi been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): Completed by Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Pregnant at time of death 5 Other (specify) Day Year ☐ Pregnant ☐ Unknown 1 ☐ Yes 2 to 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hemornage ntracranial 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certinsion After this certificate has performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 2 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per me, g912,02/08/2011dhb
State of Maryland / Department of Health and Mental Hygiene
State Amend Items 23aPtI,11,27,28a-f per me, g912,02/07/2011dnb
Reg. No. | | | | 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month December 16 **Physician** 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Y 6. Sex **Funeral** Months 1 M 2 XF Days 04-062 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore 1 Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? round Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Hack If Yes, Give Year or Dates: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Be မ 19a. Informant's Name/Relationship (Type. Print) HINTON 20b. Place of Disposition (Name of openetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signal re of Fune al Sonice Licensee MO1553 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Complications of Acetaminophen Toxicity Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) erebrat /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence on) g physician and as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as use 23c. If yes, outcome of pregnancy 1 ∠ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 ☐ Unknown P.O. 2010 9 Unknown December á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Pregnancy 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed' 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗌 Nursing Home Hospital: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28a. Date of Injury Fou(Manth, Day Year) 12/11/2010 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury or Attending 5 Pending Subject ingested Tylenol 2**X** No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 1 Yes investigation Unknown M 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Found: 2932 Round determined 4 Homicide Found: Road, Baltimore, MD Home 29a. Certifier (check only 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 December 16,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 aran 31. Date filed (Month, Day, Year) Registrar's Signature State parks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:45 PM 2010 Keefer LeGore December Rondel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 9625D Hoffman Seachrist Road Walkersville Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 26. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Months Days Hours Country Director 217-32-7242 75 1935 Marvland Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Walkersville Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9625D Hoffman Seachrist Rd 21793 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. larked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>real</u> estate 4 maste<u>r</u> appraiser permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marlin Luther LeGore Virginia Keefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4397 Taft Ct. Woodbridge, VA 22193 Rohn D. LeGore/ son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State AllCounty Cremation 4 Donation 5 Other (Specify) 12/21/2010 Sykesville, MD . Sign at ratof Fun rat Service Licens 22. Name and Address of Facility Hartzler Funeral Home allar Woodsboro, MD 21798 S. Main St 23a. Part 1. Enter the disease, or complications that caused the deal. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be execute signed by the attending physician and deed be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' After this certificate Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical pleted filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 😾 Residence 6 Other (Specify) 2 XNo 은 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending death. 1 Tyes 2 🗌 No Accident Suicide Investigation 6 Could not be s after death Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29d. Date signed (Month 20 2010

State Registrar

31. Date filed (Month, Day, Year)

12

DHMH 17 Rev 7/2009

who completed cause of death (Item

10 N

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ December 18, 2010 11:30 AM Harriett Little Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1055 W. Joppa Road Apt # 705 Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🗚 F Months Days Hours 12/11/71/922 May yand 217-18-3387 88 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21204 U.S.A. 1055 W. Joppa Road Apt # 705 "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates Specify: White 3 XWidowed 4 ☐ Divorced 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S.F.& G Assistant Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Charles Michelmann Wilhelmina Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katharine Hudson / Executor <u> 100-B Ridgewood Road Baltimore, Maryland 21210</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv. Corp. 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 12/20/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final concer mique mounder Metastatic Physician/ eurs disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live Birth 2 Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy page 2 performe Yes 2 2 No 1 Yes Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 2 1 🗌 Yes 4
Nursing Home ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) this Manner of Dea h 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No injury Natural Accident 5 Pending after death. Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) within 24 hours a To the Funeral D Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie The deficient Design of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Continued Design of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ertifie 29c. License number 29d. Date signed (Month, Day, Year) 00007830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 21093 10751 LITHERVILLE TALLS 412 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

			Please Type or Print in E					_		_	•
			1 - State of Maryland State of Maryland		artment of tificate of		and IVI	entai Hy	gien Reg. N	0010	Lagon
	Di	,	Decedent's Name (First, Middle, Last)					2. Date of De	ath	E	3. Time of Death
	Physicia Medic	al	Paul Andrew Leverton					ecembe		5 2010	1:30 P M
	Examin	er	4a. Facility Name (if not institution, give street and number) Stella Maris		4b. City, Town, Timon		of Death		4	c. County of Dea Baltimo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	-	If Under 1 Year Months Day	r If Under	24 Hrs.	8. Date of Bir (Month, Da		9. Bir	thplace (State or Foreign
7	Director		219-14-0851 1 M 2 F 86	Yrs.	Wientine	Tiouro		Sept.	1, 1	1924 Ma	ryland
Due	show	ţ		Town or Loc	cation						10d. Inside City Limits
Many	28a-f notifie	irec		ltimo1							1 Tes 2X No
ith the	23a or st be r	Funeral Director	10e. Street and Number 9021 Perring Park Rd.		10f. Zip Code 2123				10g. C	itizen of What Co US	
looth v	items er mu	F	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?		Vas Decedent of f Yes, specify Cu	Hispanic Ori	gin? (Speci	fy Yes or No-		14. Race - Ame	
DOOD STORY	al", or	d by	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No		Yes 2 🛚 N	,		our, otoly		Black, Whit	hite
	natura dical E	olete	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occ kind of work don		t of warking		16b.	Kind of Business	Industry
1.6 1.	than "	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. Do	O NOT use retire	d)	t of working	9	Λ,,,	to Suppl	ies
א ע בי	Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)	Manag	ger	18. Moth	er's Name (First, Middle,			163
ylallu H befiled	Menta arked atic ev	욘	James Leverton			All	oerta	Kral			
Na Sport	th and traum		19a. Informant's Name/Relationship (Type, Print)		ng Address (Stree Goucher					or Town, State, Zi Md. 2109	
ָבָּ בָּ	item 2			ace of Dispo	sition (Name of	1	Da		<u> </u>	Location - City or	
Dalullion	ment c		T Dullar 2 LA Cremation 3 D Removal nom State		natory or other p ervice (12 - 20	- 10		Towson,	Md.
	permit 1 age 1 and 2 blood of brings and the permit 1 age 1 and 2 blood of brings and permit 1 age 1 and 2 blood of brings and permit 1 fittem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fulferal Source Licensee	22	Name and Add RUC	ress of Facility	yn Fu	neral	Home	e, Inc. d. 21204	
			23a. Part 1. Enter the disease or complications that caused the death	_						1. 21204	Approximate
PI	rysician/	0. 9	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CONGESTIVE F	IEART	FATLURE						Interval Between Onset and Death
on E	Medical xaminer		resulting in death) Due to (or as a consequence)								
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a conseque	ence of):						- 22	
Source	and I-transit	xamine	cause. Enter Underlying Cause (Disease or linjury that initiated events c.								
be exe	ician a burial-	ш	resulting in death) Last Due to (or as a conseque	ence ot):							
oo / oo	g phys as the	Physician/Medical	d								
ath cert	ttendir or use	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal	death 3		incy				23d. Date of de	elivery Day Year
be dea	y the a	nysic	In the past 12 months: 4	eath 5L	Other (specify)					WI STATE	
that 5	gned b		Part II. Other significant conditions contributing to death but not resu	lting in the u	inderlying cause	given in Part	l.			_	o the cause of death?
SOLUS,	een sig	eted						1			Probably 4 Unknown
	e has b	Completed by						24a, Was auto perfe		prior to death?	utopsy findings available completion of cause of
ב ה ה	rtificate tor, pa	Be Co	25. Was case referred to medical examiner?		26.	Place of Dea	ath (Check o		2	No 1 □ Ye	s 2 No
hvsie	this ce al dìrec	မ	1 Yes 2 X No	ER/Outpatier 28b. Time of	nt 3 🗆 DOA						cify) HOSPICE
odina i	th. After funer	cate	27. Manner of Death 28a. Date of injury 1 X Natural 5 □ Pending 2 □ Accident Investigation 28a. Date of injury (Month, Day, Year)	injury	W	uryat ork? □ Yes 2 □		3d. Describe	how inju	ury occurred	
/ISIO	rector by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, offic	9	21	8f. Location (ıral Route Number,
	ours af eral Di filled ir		29a, Certifier 1 ☐ Certifying Physician: To the best of my knowle	odge death	occured at the tir	ne date and	place and				ated
SOH SC	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician s completed filled in by the funeral director, page 2 should be detached for use as the burial	Medical	(Check only one) 3 X Certifying Nurse Practioner: To the best of my	and/or invest	tigation, in my op	nion, death o	ccurred at tl	he time, date	and plac	ce, and due to the	cause(s) and manner state
_ F	withi To th		29b. Signature and title of certifier		29c. Lice	nse number	V3 7		29d. D	ate signed (Mont	Tr, Day, Year)
	AC		30. Name and address of person who completed cause of death (Item	23a) /Timo - F	1 //S	144	172		_/	0/00/	2010
	£ '		JACKIE JONES, CRNP 2300 DULAN	EY VA		TIM	ONIUM	, MD 2	109	3	
	Stat Registra		31 Date filed (Month Day Year) 22 Registror's Signatu	ire Wal							
	negistra	11	DEO OI TOUR OFFICE AND THE								

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 0019 A M PRIAL NESDIPTT LEE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BETHESDA MONTGOMERY SUBURBAN HOSPITAL Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birtny: Country) **Funeral** 1 XX 2 F Davs Hours JUNE 13, 1940 Director 249.58.4298 70 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 XX No MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11060 WEYMOUTH CT. 29603 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces(X) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2XXNo If Yes, Give Year or Dates Specify: Specify Completed 3 Widowed 4 Divorced **BLACK** the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 10 WASTE & WATER TREATMENT CITY/ENVIROMENTAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **NESDIPTT LEE** BESSIE MARTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **DEBRA FUNDERBURK** 103 OAKWOOD DR. GAFFNEY, SC 29341 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 ី 💢 remation 🔾 Removal from State BAYVIEW CREMATORY INC 12.15.2010 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Pensee 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. T/A MARYLAND MORTUARY SUPPORT
426 CRAIN HWY SW GLEN BURNIE, MD 21061 K. CRECORY INK M01148 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Hist only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ VENTRI CULAR FIBRILLATION Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). the attending physician and hed for use as the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the same should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has completed filled in by the funeral director, page 2 autopsy performed? Yes 2 No 1 Yes 2 Ko After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ivision of Vital Be 1 ☐ Yes 2 🗷 No 1 🗌 Inpatient 2 🛱 ER/Outpatient 3 🗀 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar w, ma

32. Registrar's Signature

TRUONG BAO, M.D. 10110 MOLECULAR DR. ROCKVILLE, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
DEC 212010

00057124

12/13/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8&9 Per FH G910 12/21/10 Jh State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHN MARK onth C 00 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MATLEY 1607 GIEN SUVNIC . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days (Month, Day, Year 7-23-1960 Months Hours Min Jequitry 23, 1960 MD 214-88-6649 1 XM 2 F 50 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. notified at 10d. Inside City Limits Director Glen Burnie MD Anne Arundel 1 Yes & No ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? traumatic event, the Medical Examiner must be 23a Funeral 1607 Marley Ave USA 21061 "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2xx No If Yes, specify Cuban, Mexican, Puerto Rican. etc.) Black, White, etc. 1 ★ Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) MTA Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elsie L. Greenwood Edward E. League, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 1607 Marley Ave., Glen Burnie, MD 21061 Mother Elsie L. League 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 x Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (S Glen Haven Cemetery Dec 27, 2010 Glen Burnie, MD ture of Funeral Servi Name and Address of Facility Fink Funeral Home, P.A. M01148 Grego 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1, Enter the omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine as a consequence the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Yes 2 ☐ No 9 Unknown the 9 Unknown b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 2,2 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 🗌 Pending work? 2 🗌 No

Division of Vital Records, P.O. Box 68760

within 24 hours after death.

To the Funeral Director: After 0

State

Registrar

Medical

Accident

Homicide

Suicide

29a. Certifier (Check

unity unit

29b. Signature and title of certifier

Investigation 6 Could not be

address of person who completed cause of death (Item 23a) (Type, Print)

ones

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause.

Gertifying Nurse Practioner: To the best of my knowledge, death constructed the time, delviced place, and due to the consolet and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0605

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

21035

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Bradford Oaks Nursing Home Clinton If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Hours 06/28/ Virginia 231-42-4065 1934 76 Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State with the Maryland event, the Medical Examiner must be notified at Director MD PG Fairmont 1 Yes 2 ☐ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 702 60th Avenue 20743 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No b ò 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify:Black "natural" 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Telephone Operator 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ UNK Laura Cashwell Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christian A. Meredith/Husband 702 60th Avenue; Fairmont, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Chespeake Crematory 12/20/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Pnysician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or Ilinjury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an cate has I autopsy performed? Yes 2 No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be 2 🗡 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2010 Frank M. KYAN MI son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

21

20744

Livingston Road #203; Fort Washington, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Van Joseph Malone, Jr December 1:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PG Mitchellville Villa Rosa Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □**X**M 2 □ F Hours 83 0671571927 Michigan **Director** 415-34-4563 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director or 28a-f 1 X Yes 2 No PG Landover MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 1014 Hill Road 20785 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black "natural" Completed 3 X Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 years Miltary U. S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic eve ၉ Alexander Van Joseph Malone, Sr. Florence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Smith / Daughter 1014 Hill Road; Landover, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD Veteran Cemetery : 01/04/2011 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of uneral Service Licensee 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, 23a. Parl 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) **Examiner** months Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit iears Due to (or as a consequence of): resulting in death) Last certificate has been signed by the attending physician irector, page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atten completed filled in by the funeral director, page 2 should be detached for u in the past 12 months? Month Year Day 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 P No ၉ 1 🗆 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical

State

Registrar DHMH 17 Rev 7/2009 29a. Certifier

29b. Signature

(Check only one

Bichard

3 🗌

nd title of cert

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Feldman MD

8116

32. Registra 's Signature,

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Good Luck Road : Lanham, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Munsey Day Year Month Physician/ Robert 10 4:36 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death of Maryland Medical Center BaHIMOre 5. Social Security Number 7 Age (In vrs. last hirthday) If Under 1 Year | If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral Days Hours Min. Dec 5 1 **X** M 2 □ F Months 1990 Maryland 20 Yrs. Director 214-31-6387 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 ☑ No Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4712 Lynn Burke Road 21770 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ō Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: "natural" 3 Divorced 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 n/a n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H is marked ot ပ Clayton Elizabeth James Carole Pittore Munsey traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau Carole Munsey/mother 21 370 4712 Lynn Burke Road Monrovia, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 12/20/2010 Woodbifte, 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M atriar M00957 MD Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Multiple Injuries with Complications Approximate Interval Between Onset and Death Immediate Cause (Final MVC with Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) certificate be executed the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 for use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed certificate 2 🛛 No 25. Was case referred to medical exampler?

1 🗹 Yes 2 🗆 No or Attending Physician: To Be Division of Vital completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t injury 5 \square Pending ☐ Matural ☐ Accident work? Motor Vehicle Accident 2 M No hours after death. Ineral Director: A 10:00 12-14-2010 Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Monnia To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 2610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 ND 22 Greene St Ba Himbre 5 Damon

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 1

Dark

Registrar's Signature

ND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12 Month 2010 Day Walter Lee Moore, 18 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crofton Convalescent Anne Arundel Center Crofton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 M.D. **Funeral** 1, M A D F Days Hours Min Of 1 2 Months Director 216 14 4061 88 MD Usual Residence of Decedent fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 825 Elmhurst Rd 21144 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces'
1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married ^{2 □} № **1**943 Baltimore, Maryland 21215-0036 1 ☐ Yes 2. No Specify: Completed 3 X Widowed 4 □ Divorced 1945 Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Truck Driver Amtote Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Moore Mary A. Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20720 Deborah Kent - daughter .2700 Hill Meade Station Dr Bowie, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 112/22/10 Crownsville, MD Veterans Cem MD22. Name and Address of Facility GJ Gonce Funeral Home, PA 160 Riviera Drive Pasadena, MD 21122 21. Signature of uneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due o (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown signed by the ar g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy r this certificate had director, page perform Yes 2 No 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မှ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After thi leted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 2

State Registrar (Check

only one) 29b. Signature and title of certifi

31. Date fled (Month, Day, Year UEC 2 1 20

who completed cause of death (Item 23a) (Type, Print)

32. R

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MD 2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Perate of Maryland Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 15 M Physician/ 2010 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner N/A Ballinne Street Allenda (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral Min. Hours Months 1 🗆 M 2 🖼 AROlinA -16-5958 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Baltimore 10g. Citizen of What Country? 10e Street and Number Funeral 21229 Allendale Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ 1 ☐ Yes 2 ☑ No Specify: Specify: Black Maryland 21215-0036 If Yes, Give 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Deceagent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

The Clerk College (1-4 or 5+) Baker Elementary/Seconday (0-12) 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ည alvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Allendale Street Baltimore, MD Deanna Mile-Brown 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State Baltimore, Dac 27,10 ouden Parl 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Regularity Fureral Service pass. Back. Mas 21. Signature of Funeral Service Licensee once. muld 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EMENTI Immediate Cause (Final disease or condition ASCULAR Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Vear Month Day in the past 12 months? Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LYMPHOMA 2010 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 1 🗌 Yes 🗻 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death Natural Accident 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 20a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 N Rodo 82. Registrar's Signature 31. Date filed (Month, Day, Year, Registrar

			State of Maryland / Department of Health and Mental Hygiene - State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 0									40288	_	
	Physicia		1. Decedent's Name (First, Middle, Last) Sarah Kathryn McLain							2. Date of Death Month Day Year 12:50 PM				
á	Medic Examin	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea											
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		5. Social Security Number 214-16-8671	6. Sex 1 M 2 X F	DICAL CENTER 7. Age (In yrs. last birthday M 2 🖫 F 96 Yrs.		If Under 1 Year If Under 24 H		der 24 Hrs.			9. Birth	nplace (State or Foreign ntn) Y Land	
		ž	Usual Residence of Decedent 10a. State 10b. County		10c. City,		Town or Location						10d. Inside City Limits	-
		Funeral Director	MD		Baltimor								1 🗌 Yes 2 🛣 No	
		ralD	10e. Street and Number 1300 Regester	Λιτοριιο	tie.			10f. Zip Code 21239			10g. Citize	untry?		
dw de		۾	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☒ Widowed 4 □ Divorce	12. Was Dec	2 █ No √e		Was Decedent of Yes, specify C	of Hispanic uban, Mexi	can, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White pecify:		
		Completed		ent's Education est grade completed College (*)	(Give life, D	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) OMEMAKET			ing		of Business I	•	-
		To Be	17. Father's Name (First, Middle, George Ja	•	Holmes	;		- I	other's Name	e (First, Middle,	Maiden Su Wotc			
			19a. Informant's Name/Relations Nancy Ford / I							al Route Numbe Baltim				
			20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from	State		natory or other	olace)	1	Date 0/2010		ation - City or		
			4 ☑ Donation 5 ☐ Other 21. Signature of Funeral Service] Ar		2. Name and Ad	dress of Fa	cility An	atomy G	ifts	Regist		
	Physician/ Medical		23a. Part 1. Enter the disease, c shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on e	ach line. VEUY	eath. Do not ent	er the mode of o						Approximate Interval Between Onset and Ceath	
	Examiner	e.	Sequentially list conditions,	b. ———	(or as a cons									_
	ate be executed oblysician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Unsease or iinjury that initiated events resulting in death) Last	с	Due to (or as a consequence of): Due to (or as a consequence of):							-	_	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	edical		d										_
Box 687		Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	Was decedent pregnant 23c. If yes, outcome of pregnancy							23	23d. Date of delivery Month Day Year		
s, P.O.		d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did								d tobacco use contribute to the cause of death?			
Division of Vital Records, P.O.		omplete		_						24a. Was autop perfo	osy ormed?	prior to death?	opsy findings available completion of cause of	
tal R		BeC	25. Was case referred to medical examiner?									34 No	_	
of Vi			P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Othe										fy)	_
sion		Certificate:	3 Suicide 6 Could	tigation	(Month, Day, Year) injury work? I □ Yes 2 □ No									
Divis				build	building, etc. (Specify) City or Town, State)									_
		Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
			29b. Signature and title of pertific	14	M	0		ense numb			29d. Date	signed (Month	2010	
	()		30. Name and address of person	who completed cau	se of death (I	tem 23a) (Type,	Print) 7601	OSL	en Z	RIVE 7	Tows	ON M	21204 ARYLAND	
	Sta	te	31. Date filed (Month, Day, Year)	32.1	Registrar's Sig	mature	A					7		_

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear 2:35 A Elizabeth 19 2010 Lavina Moran December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Hospice Unit <u>Randallstown</u> Baltimore 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Days Hours Maryland Months Min 12/06/1924 86 218-18-6795 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1206 Stella Drive 21207 U.S.A. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes. Give "natural", White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown မ John Lewis Ε. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Buckheit / Son 1206 Stella Drive, Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatany Gifts Registry 12/21/2010 | Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) 21. Signature of F eral Service Leansee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive, Ste. P, Hanover, MD 21076 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each fine. Onset and Death Immediate Cause (Final Ph_sician/ Matox disease or condition resulting in death) Medical Due to (or *s = consequence of): Examiner Zulls Signer tight list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the burial-transi Cause (Disease or linjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mopths?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 4 Pregnant g Unknown 1 Yes 2 b been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 Yes 2 No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence P 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 No within 24 hours after death. To the Funeral Director, A Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 2010

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

MITIMOLE

Te 205

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KANCO W. MENULTI 2835 SHITH A

2835

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month VIAN] NOY 2010 Medical Eacility Name (if not institution, give street and number Town, or Lipcation of Death 4c. County of Death **Examiner** 8. Date of Birth Social Security Number If Under 1 Year If Under 24 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. 1 🗆 M 2 🔀 F Yrs. Director 64 225-68-9971 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. 414 North Bend Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates. Black 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Domino Sugar Co. 12th grade Line Worker 2 should be filed with h and Mental Hygien 7 is marked other tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Frances Cook Dewey Cheppell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau Andrea Wilson-Daughter Tralee Cir., Aberdeen, Md 21001 1361 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State King Memorial Park 12/22/2010 Woodlawn, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Pa 1. Enter the disease, or complications that ship k, or hear failure. List only one call by on each line. the death. Do not enter the mode of dying, such as cardia; or respiratory arrest, Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical attending ph for use as th IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown g | Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 autopsy death? Yes 2 N 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 110 Other: 1 Tes ပ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending (Month, Day, Year) Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) -16-2010 (Type, Print) 32. Registrar's Signature

Registrar

3altimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Month Da 2010 Physician/ 9:40 a.M James Morrison Medical 4a. Facility Name (if not institution, give street and number or Location of Death 4c. County of Death Examiner Town Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Security Number **Funeral** (Month, Day, Months Hours Min Country 1 🛛 M 2 🗆 F 215-28-3738 78 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County death with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits Director XX Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1208 Carroll Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. African þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Specify: American "natural". 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Co. 12th Grade Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental Hr tant: If item 27 is marked otl ijury or other traumatic even မ Barksdale Η. Crawley James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 Carroll Street Baltimore, MD 21230 Morrison-Wife Margaret Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Garrison Forest 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department or Important: If any injury or 12-28-10 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Wylie Funeral Home Baltimore, MD 21217 638 N. Gilmor Street 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final and Death Ph sician/ a, (a disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examiner Due to (or as a consequen le the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death
Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law has autopsy performe death? After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; to 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be aminer? Other: 2 No Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending work? 1 🗌 Yes 2 🗆 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) Nee filed (Month, Day, Year) 32. Registrar's Signature State 2010 2 1 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 25 per me g916 6-6-11 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 22:2 December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) If Under 24 Hrs 8 Date of Rinth **Funeral 2**M 2 □ F Maryland Director 63 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X□ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21229 10 N. Rock Glen Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 💢 No Specify: Specify: white 3 Widowed 4 N Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk unk (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Harry McFadden Mary Frances Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Shoop/sister 3649 Clarendell Road Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🖫 Other (Specify) in state ²². Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signat of Funer Service Licensee Hald S. Wade rector 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 🙎 🗐 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed this certificate has 2 Rio Yes 1 Yes 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be examiner?

1 X Yes Hospital Other: ပ္ 1 Inpatient 2 R/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completed filled in by the fu 1 Yes 2 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and little of 30. Name and address of person who completed cause of death (Itom 23a) (Type Noneil m ACHEN EC 21 State Registrar

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ December Charles M. Moll Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Dundalk Futurecare Northpoint Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Ye ar 26, Days 1 🕅 M 2 🗆 F Months Hours Min Director 56 Mar 216-62-8886 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1919 Armco Way 21222 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 🔀 Divorced Completed 202 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 10 truck driver Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) မ Charles M. Moll Sr permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1919 Armco Way Dundalk, MD 21222 Barbara Lowe/friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade, Director PER DVR MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) End iver Physician/ Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 호 anemia Completed 24a. Was an autopsy within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #21 PER DVR G910 12/21/10 JH State of Maryland / Department of Health and Mental Hygiene

20c. Location - City or Town, State 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) D 69540. 14 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8513 halkam words kd Suite 204 Parkville MD 21234

Time of Death

g. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 😾 No

unk

6:10 AMM

2010

Baltimore

14. Race - American Indian,

lumber company

Black, White, etc.

Specify: white

Mary Land

4c. County of Death

USA

Ĩ954

State

Jigar Shah 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:00 James William McKnight December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 5908 Pontiac Street Berwyn Heights Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 3, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🖾 M 2 🗆 F Days Hours Min 73 Director 183-28**-**5855 1937 Kittanning, PA Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 🏿 Yes 2 🗆 No Maryland Prince George's Berwyn Heights 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5908 Pontiac Street 20740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give 10 3 Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 X Widowed 4 Divorced Year or Dates. 1959-1962 Completed event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Elementary/Seconday (0-12) Giant Food Corporation Computer Programmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Thomas McKnight Josephine Emma Martz 19a. înformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Yumiko M. Fletcher / Daughter 10 Main Street, Noank, CT 06340 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 cemetery, crematory or other place)
Metropolitan Crematory 1 Burial 2 S Cremation 3 Removal from State 12/20/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. Potry Resers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician Laryngeal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of: If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury transit certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-t Physician/Medical Box 68760 attending ph I for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) the a Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Breast Cancer Records, 1 🖾 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed should 24b. Were autopsy findings available 24a, Was an page 2 s prior to completion of cause of death? certificate has performe 2 🗌 No Yes 2 X No 1 Yes Division of Vital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: ours after death.

neral Director, After this or
filled in by the funeral dire 2 🛛 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours a Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D26287 12/20/2010

State Registrar DHMH 17 Rev 7/2009 7305 Baltimore Avenue, #107, College Park, MD 20740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Michael J. Berard,

31. Date filed (Month, Day, Year)

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** senior 405AM 2010 VIOrri /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hatthcare e550W1 Nashing ta Under 10 ear If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Jan. 4, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1**⊠**M 2□F Months Days 43 Yrs. Ĩ967 220-64-2763 Maryland **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director PA Adams Gettysburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 128 West Middle Street 17325 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Disabled N/A permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other than any injury or other treumatic event, IIIA 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lee Morris Theresa Marie Knott 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nannette Morris - Wife 128 W. Middle Street, Gettysburg, PA 17325 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ Removal from State 12-16-2010 4 Donation 5 Other (Specify)
Signature of Figure Service Licensee tlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) irrhosis LIVER **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed burial-fransit Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 Yes 2 No certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ٩ 1 Yes 2 No 4. ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this After this funeral of 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Hospitel or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier R1185 cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 4014 PIKE 32. Registra 's Signature

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records.

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature parks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit Singh, M.D. 5410-A Ritchie Hwy.

ORIGINAL

21225

Brooklyn Park, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dec. Physician/ MacKabee Gerard 2010° 12:27 AM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Co. Middle River Ivy Hall Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**XX**M 2 □ F Months Days Hours Min. Feb. 2, 1924 Maryland Director 86 215-14-6942 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits with the Maryland rector 1 Yes 2 No Dunda1k MD Baltimore ۵ 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 21222 1967 Frames Road United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4XX Divorced White Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant. If item 27 is marked other than "natuiury or other traumatic event, the Medical iury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 Years College (1-4 or 5+) 2 Years State of Maryland Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Luella Trott Thomas S. MacKabee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1967 Frames Road Dundalk, Maryland (Son) Mr. John T. MacKabee Department of Health Important: If item 2; any injury or other toonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 2/21/20101 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Owings Mills, MD Garrison Forest V.A. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a confequence of): disease or condition Medical resulting in death) Examiner emente Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) resulting in death) Last physiclan Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Jomat Diseane 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🔲 No Yes Yes filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 24 hours after death. Funeral Director: Af 1 Yes 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) MD 31464 12/16/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. BUTAW ST Phite 308 BALTIMORE MP MD, SHOAIB HASHMI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 Year Ruby С. Nelson 1:00P M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air <u> Harford</u> 6. Sex Funeral Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 ☐ M 2 🗓 F Days Min. (Month, Day, Year) 04/09/1916 Months Hours Director 220-16-5190 94 VA Usual Residence of Decedent show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director MD 1 Yes 2 X No Harford Havre De Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 806 Shawnee Brooke Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 🕅 Widowed 4 🗆 Divorced White and Mental Hygiene.

is marked other than "natur aumatic event, the Medical" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Work 11 Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elbert Cantrel1 Nettie Rutherford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Mrs. Gwen N. Walters / Daughter 806 Shawn<u>ee Brooke Drive</u> Havre De Grace, MD 21078 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 12/20/2010 Elkridge, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Le. Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate oause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 1 Yes No certificate has been signed by the rector, page 2 should be detached Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2/2NO 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 242 No Hospital Other: မ 1 🗌 Yes Nopatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel JOKHADAK UHAMMAD 500 Upper 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Sandra Nally Certificate of Death 1- For State Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ 0100 hrs December 18, 2010 "cal Examiner Nallv Sandra 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 228 South Robinson Street 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number Funeral Hours Months Days Country) MD Director 49 07/18/1961 216-80-2322 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No s 23a nr 28a-f shnw e notified at once. MD Baltimore N/A Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21224 U.S.A. 228 South Robinson Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funera 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No 1 Yes Specify: White 3 Widowed 4 Divorced f Yes, Give Year Yes 2 X No specify: \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. marked other than "r c event, the Medical E MD 21215-0036 Johns Hopkins Physician Referral 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Be George Nally 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 783 Velvet Run Drive, Westminster, Jacqueline Kelly, Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore. crematory or other place) Baltimore
permit. Pages 1:
Department of H.
Impurtant: If it Burial 2 X Cremation 3 Removal from State 12/20/2010 Towson, Maryland Hilltop Svc. Corporation 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 llerandia Blan Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Complications of morbid obesity Immediate Cause (Final disease Ėxaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED the attending physician red for use as the burial Division of Vital Records, P.O. Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day 1 Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 V Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed' death? Yes Yes 2 V No this certificate 26.Place of Death (Check only one) director, 1 25. Was case referred to medical Be Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 Yes 2 No 5 Pending filled in by the Directur: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. ___ Suicide 6 Could not be or Town, State) within 24 hours a To the Funeral I determined Homicide 29a. Certifier (Check only one)

29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 20, 2010 O.C.M.E. Me JA Name and address of person who complete Lause of death (Item 23a 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registra

amend 37 & Fer ANA BD G910 Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $^{Day}5$, 20TO Beatrice K. O'Donnell December 10:56 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Funeral Ocure of Pith 1945 1 □ M 2 🔯 F Months Davs Hours Min Marvland -83 Director 148-34-8105 Usual Residence of Decedent 28a-f show 10a, State 10b. County at 10c. City, Town or Location 10d. Inside City Limits illed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes 2x No MD Anne Arundel Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21403 USA 203-J Victor Pkwy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 10 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white "natural" Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event the Man life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Beatrice Ellen Kirtley Joseph Dean O'Donnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Walnut Street Exiter, NH Joseph C. O'Donnell/brother 03833 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🗌 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 X Donation 5 Other (Specify) of Fred Service Licensee Lonald S. Wade ure of Filmeral ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street regtor MD 21201 altimore. Enter the disease, or complications that caused the death 23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conse luence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Dav Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed certificate has page 2 1 ☐ Yes 2 ☐ No Yes 2 □No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital Other: 1 Yes 2 🗌 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death nours after death. neral Director: After the filled in by the funeral 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral C To the Hospital Medical 🗹 Certifying Physician: 🄀 the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: 2n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and little of certific 29c. License number 29d. Date signed (Month. Day, Year 3 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 31. Date filed (Month, Day, 32 Registrar's Signatu Year) State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 5:38-M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NIA emoria Hmore 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1 M 2 F Hours Yrs Director Usual Residence of Decedent 28a-f shov 10b. County er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No alti mae 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married 2 100 ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. PO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) erica Be 17, Father's Name (First, Middle, Last) မှ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21200 More 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State salti mos Donation 5 Other (Specify) 21. Signature of Funeral Service License Himure 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on jach line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in listed as or injury Examine Due to (or as a consequence of). and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of); physician a the burial-Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown cate has been significated to should to the same of th Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform After this certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of cettifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 192 20 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201°0 Dewey Pickett Dec. 4:05 A.M Norman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Northampton Manor Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1 😡 M 2 🗆 F Months Days Hours Country) Mary Land 215-20-7788 86 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2XXNo Maryland Carroll Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò with 23a Funeral 21797 5907 Woodbine Road United States items ? 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Bace - American Indian. Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 X Married ∐Yes 2 🗓 XQo Maryland 21215-0036 1 ☐ Yes 2 🔀 🗙 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) American University 11th Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ellis Dewey Pickett Bertha Pearl Lindsay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 133 Liberty Street Westminster, MD Denton W. Pickett Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Pleasant Ridge Cem. Dec.23,201 Winfield, MD Donation 5 Other (Specify) Burrier-Queen Funeral Home & Crematory, PA

1212 W. Old Liberty Road Winfield, MD 21784

23a Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate ature of Funeral Service Pensee Approximate Interval Between Immediate Cause (Final Cardovesculor Onset and Death diserse Physician pertensive disease or condition resulting in death) reass Medical Due to (or as a consequence of) Examiner constitute list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death the Unknown 9 Unknown P.O. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be (Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 s this certificate 2 No 1 Yes 25. Was case referred to medica examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After iniury work?
1 Yes 2 No 1 Natural 5 Pending __ Accident after death Investigation 6 Could not be within 24 hours after des To the Funeral Director completed filled in by th Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title 026499 12-20-10

Registrar
DHMH 17 Rev 7/2009

State

#4 Culwell Dr., Mt. Airy, MD 21771

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

arks

Dr. Ronald Miller

2010

31. Date filed (Month, Day, Year,

21

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 10:00 PM December 2010 Robert Lee Quave Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 10283 Gainsborough Road Potomac Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Yrs Director 411-50-7020 February 2, Tennessee Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No Potomac Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20854 United States 10283 Gainsborough Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 X Yes 2 No 1959-Completed by 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: than "natural", Specify: White 3 Widowed 4 Divorced 1960 traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4 Administration Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Caroline Ernestine McCants Morris Winner Quave ge 1 and 2 should be nt of Health and Mer :: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10283 Gainsborough Road, Potomac, Maryland 20854 Helen A. Quave/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott December 18. Montgomery or other place) 1 Dunal 2 XCremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Bethesda, Maryland Crematorium, Inc Robert A. Pumphrey Funeral Home, Rockville, Inc 300 W. Montgomery Ave., Rockville, MD 20850 Signature of Funeral Service 1aum M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
Months Immediate Cause (Final Physician/ disease or condition resulting in death) Non small cell lung cancer Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending place as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Dav Year as been signed by the 2 should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has autopsy performed? Yes 2 X page 2 🗌 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be 2 X No Hospital: Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) MP D0066990 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6420 Rockledge Drive #4100, Bethesda, Maryland 20817 Vinni Juneja, M.D., 31. Date filed (Month, Day Year) 32. Registrar's Sign ture State Registrar

XDHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nø. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeta Physician/ Rekus 9:44 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Baltimore Mercy Medical Center None . Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours 1 🗆 M 2 12/02/1951 ear) New York Director 091-44-7637 Yrs. Usual Residence of Decedent 10a. State 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 XXNo Maryland Anne Arundel 0denton 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 700 Thornwood Drive 21113 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 XXMarried "natural", or 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XX Specify: Specify: 3 Divorced 4 Divorced White Year or Dates is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse State of Maryland Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Robert E. Lee Sr. 27 is marker r traumatic Virginia E. Obermeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Richard Rekus Husband 700 Thornwood Drive Odenton, Maryland 21113 Department of Health Important: If item 27 any injury or other treatment. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State GreenMount Crematory 12/23/2010 Baltimore, Maryland Donation 5 D Other (Specify) nature of Funeral Servi 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, shock, or heart failure. Li complic Approximate Interval Between Onset and Death Immediate Cause (Final carcinosoncoma di Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir led by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown P.O. cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific: completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practione: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WPI 1063671105 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Balkmore, MD 21201 301 MD 32. Registrer's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 19, Year 19 Physician/ Betty Jane Ricci 4:30a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 619 Norris Lane Essex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 1 🗆 M 2 😾 F Hours Min (Month, Day, 194-24-3706 Director 79 2-1931 Usual Residence of Decedent shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Essex **Baltimore** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 Funeral 619 Norris Lane USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married 1 ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) In own home Homemaker 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Gallagher Dorothy King 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Michael D. Ricci 619 Norris Lane, Essex, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date west Arundel Crem. 12-20-10 1 Burial 2 Cremation 3 Removal from State Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N 21. Signature of Funeral Service Licensee Zannino Jr.FH S.Conkling St., Baltimore, MD 21224 263 23a. Part 1 Enter the dis shock, or heart fail Immediate Cause (Final se, or complications hat caused the death. Do not enter the mode of dying, such as cardiac in respiratory arrest, List only one cruse in each line. Approximate Interval Between Onset and Death Physician/ iren disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or self-conesquence of): Exami and -transit Hospital or Atter ding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent preon 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) Pregnant at time of death by the a 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 246. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page death? this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 After this certification 25. Was case referred to examiner? æ 26. Place of Death (Check only one) Hospital မြ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director Aft completed filled in by the fun 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death acc urred at the time, date and place, and due to the cause(s) and manner as stated. only o 3 🗌 29b. Sia 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Day, Year) 2 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 2:50 Vangala Jaya Ram Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care/Bethesda Montgomery Bethesda 8. Date of Birth (Month, Day October 7 **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1**X** M 2 □ F Days Hours Min. Country) India **Director** 127-38-4525 October Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified ** once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4808 Moorland Lane #713 20814 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 2 X No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) United Nations Diplomat Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Das Vani Bai Vangala S. Ram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Van S. Ram/Son 4808 Moorland Lane #713, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of December Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2010 Bethesda, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. the the M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death 5 Minutes Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Years Hypertension Due to (or as a consequence of): resulting in death) Last Physician/Medical Years Diabetes Mellitus Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chronic Renal Failure 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pendina work' 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examines, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

DHMH 17 Rev 7/2009

only one)

29b. Signature and title of certifier

Raman Tuli, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

60

M.D. 10810 Darnestown Road #202, Gaithersburg, Maryland 20878

December 14, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17, 2010^{ar} James F. Rice December 3:00 A. Medical 4a. Facility Name (if not institution, give street and number)
2403 Fleetwood Avenue 4b. City, Town, or Location of Death Baltimore Examiner 4c County of Death Baltimore City 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 236-44-6030 Days Hours Min 1 XM 2 - F August 222 Yea 1930 West Virginia **Director** Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore Maryland 1 Yes 2 I No 10f. Zin Code 21214 10e. Street and Number 2403 Fleetwood Avenue 10g. Gitizen of What Country? Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status was becedent Ever in 0.5.
Armed Forces?

1 X Yes 2 National
If Yes, Give National
Year or Dates. Guard Black, White, etc. 1 Never Married 2 X Married ò Baltimore, Maryland 21215-0036 1 Tes 2 No Specify Specify: white Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Envelope Manufacturing Machine Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Fred Rice Mary Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine L. Rice/ Wife 2403 Fleetwood Avenue Baltimore Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Gardens of Faith 12/20/10 Baltimore Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leopland J. Ruck: Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 12 mentio Many years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami to the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 N 2 No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier December 17, 2010 D0052583 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Blud.

32. Registrar's Signature

ساسلامها

Laren

31. Date filed (Month, Day, Year)

DEC

Baltimore, MD

21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20^{Year} December Walter Joseph Ruppert, III 8:42 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest Hospital Center Randallstown 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Aug 8, 1958 7. Age (In vrs. last birthday) **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign 1 1 M 2 □ F Months Days Hours Maryland Yrs Director 220-72-2811 52 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 214 Highmeadow Road U.S.A. 21136 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 ☐ Never Married 2 🔀 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Distributor Newspaper Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o ည Walter J. Ruppert, Jr. Evelyn Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Ruppert Wife 214 Highmeadow Road Reisterstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Carroll Cremation 12/18/2010 Hampstead, Maryland 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or meart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ percalcemia disease or condition resulting in death) Medical as a consequence of Examiner Carcinoma Squamous Sequentially list conditions, ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of. physician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 🗌 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? certificate I 1 Yes 2 No Be (25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this of in by the funeral dir 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending Recember 11,2010 Unknown 1 28e. Place of Injury - At home, farm, street, factory, office 1 Tes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number Rd, City or Town, State) 214 High Meadow Rd, ReisTers fown, MD 21136 4 Homicide determined building, etc. (Specify) Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 33a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

apper

Walter

Tri

MD

32. Registrar's Signature

1	0	3	0	
	1	-	10	

			1 - State Amend Items Registrar	24a,25,26,2	7,255 Cer	per dr tificate of L	g 910,12/ Seath	21/2010	dhb Reg. No.		
	Physicia	n/	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Yea	3. Time of Death	
1	Medic	al	Joyce Rigne					12-06	5-2010	8:20 P M	
	Examin	er	4a. Facility Name (if not institution, give street	·		4b. City, Town, or			4c. County of De		
and the	Francis		1210 Canvasbac 5. Social Security Number 6. Sex	7. Age (In yrs. last	t hirthday)	Upper If Under 1 Year	Marlbo	TO	P.		
٦	Funeral Director		208-32-7400		Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year) Country)		
	ind ihow at	'n	10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits	
	laryla 3a-f s ified	ect	MD P.G.	Upi	per M	Marlboro)			1 🕱 Yes 2 □ No	
	or 28	ΩÏ	10e. Street and Number	I OF	<u> </u>	10f. Zip Code			10g. Citizen of What	Country?	
	with s 23a ust b	Funeral Director	1210 Canvasbac	k Ct.		20	774		U.S		
	item item	Fur		Vas Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No-	14. Race - Ar	nerican Indian,	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	ed by	1 Never Married 2 Married 1	Yes 2 X No Yes, Give lear or Dates.		☐ Yes 2 🔀 No		5 moun, 6:6.,	Diaok, W	Black	
5-0	2 hou "natu dieal	Be Completed	15. Decedent's Education (Specify only highest grade co		16a. Deced	ent's Usual Occupa ind of work done di	ation	kina	16b. Kind of Busines	ss Industry	
21	hin 7% ne. than	mo	Elementary/Seconday (0-12)	ollege (1-4 or 5+)	life. DC	NOT use retired)	-	King	D		
2	d wit Hygie ther nt, th	3e C	11th Grade		H	<u>ousewif</u>		(P ²)		estic	
anc	oe file set o ked o c eve	10	Martin Walters					ne (First, Middle, therine	Maiden Surname) Turner		
Ž	ould I		19a. Informant's Name/Relationship (Type, Pi	int)	10h Mailin	a Address (Street a			er, City or Town, State,		
Baltimore, Maryland	nd 2 sh lealth ar m 27 is her trau		Karen Woodridge/D	aughter	1210	Canvasb	ack Ct.	/Upper	Marlboro	, MD 20774	
lore	ge 1 a it of H if ite or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Remo	val from State cen	netery, crem	sition (Name of atory or other place		Date	20c. Location - City		
ţim	it. Pac rtmen rtant: njury		4 Donation 5 Other (Specify)	Chel		am Vet.				nham, MD	
Ba	permi Depar Impor any ir		21. Signature of Funeral Service Licensee) illumid					rellingto W/Wash.,	on Funeral DC 20011	
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ons that caused the death.	Do not ente	r the mode of dying	, such as cardiac	or respiratory an	rest,	Approximate Interval Between	
	nysician/	0.1	Immediate Cause (Final disease or condition	Chronic R	enal	Failure	9			Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):						
		-er	Sequentially list conditions, b. — if any, leading to immediate	Due to (or as a consequer	nce off:						
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or linjury	Dao to (or as a sonisoquer	100 01).						
	n and al-tra	Exa	that initiated events c. — resulting in death) Last	Due to (or as a consequer	nce of):	_					
0	cate be executed physician and the burial-transit	ical									
8760	ificate ig phy as th	Med	IF FEMALE:								
ω ×	n cert tendir r use	an/I	23b. Was decedent pregnant 23c. If	yes, outcome of pregnanc		Ectopic pregnancy	,		23d. Date of	delivery	
P.O. Box 68	e deat the at hed fo	Physician/Medical	1 Yes 2 No 4	☐ Pregnant at time of dea☐ Unknown	ath 5	Other (specify)			Month	Day Year	
Ö.	hat th ed by detac	y Ph	Part II. Other significant conditions contribu	ting to death but not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?	
S,	ulres t sign lld be	q p						1 🗆 '	Yes 2 No 3	Probably 4 🗆 Unknown	
ord	w requ	Completed by						24a. Was		autopsy findings available	
3ec	sician: The law is certificate has the law irector, page 2 s	mo						autop perfo 1 🗆 Yes		o completion of cause of ? es 2 \sum No	
a	ian: T	Be C	25. Was case referred to medical examiner?			26. Pla	ce of Death (Chec		2401101 1 1 1	es 2 🗆 140	
₹	hysic nis ce I direc	10	1 Yes 2 No	al: 1	R/Outpatient	: 3 ☐ DOA Other	r: 4 🗌 Nursing H	ome 5 X Resid	dence 6 Other (Spe	ecify)	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	Ba. Date of injury 28 (Month, Day, Year)	Bb. Time of injury	28c. Injury work? M 1 🗆 N		28d. Describe h	ow injury occurred		
/isic	r Atte	ertif	3 Suicide 6 Could not be	e. Place of Injury - At home	e, farm, stre	et, factory, office			Street and Number or F	Rural Route Number,	
S to the G of the City or Town, State)											
-	ne Hosp in 24 ho ne Fune pleted f	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of rhy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								e cause(s) and manner stated.	
	To the company of the	-	29b. Signature and title of certifier	200 = 1		29c. License	number		29d. Date signed (Mor	nth, Day, Year)	
			man eu			D2:	3743		12-9-	2010	
			30. Name and address of person who comple					, -		5 0	
	Su-		Martin Weltz, M. I 31. Date filed (Month, Day, Year)				Dr./Gr	eenbel	t, MD 207	70	
	Stat Registra		NFC 2.1 2010	32. Registrar's Signature	Jeark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:40 Dorothy Μ. Reese December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Long View Nursing Home Carrol1 Manchester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
May 17, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 X F Director 90 220-09-2144 MDUsual Residence of Decedent 28a-f shov and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified (MD 1 🗆 Yes 2 😾 No Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13 Rain Flower Path 21152 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 🕅 Widowed 4 🗆 Divorced Specify: White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Otter Clarence Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara C. Toher Daughter 5401 Weywood Drive, Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 12/21/10 Timonium, MD Signature of Funeral Service License 22. Name and Address of Facility 11824 Reisterstown Road Bens 70 ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Confestivo disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** quentially list our citions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 🗌 Unknown Part II. **Other signific**an**t condition**s contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tyes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 X No Other: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No М Investigation within 24 hours after des

To the Funeral Director

completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

B1. Date filed (Month, Day, Year)

REC 2 1 2010

e or certifier whipa, Mr

30. Name and address of person who completed cause of death (Item 26a) (Tyte, Print) M ドルドリミソスト 3 午9 がないかいかん

Curtifying Nurse Practioner. To the best of my knowledge, seeth consisted at the fline, date and place, and due to the

349 malustra

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

51705

29d. Date signed (Month, Day, Year)

12-17-10

DR, Westminster MOXILST

29c. License number

DHMH 17 Rev 1/2001

State Registrar

Stull, Denald

Caton Ave. Baltimore, MD 21229.

900 S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chandra

31. Date filed (Month, Day, Year)

Shreether

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DECEMBER 12:45 P M DOUGLAS L SCHLOTTERBECK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 🛣 M 2 🗆 F Days Hours Min. 3/10/1931 Director Yrs 79 MD 220-26-5698 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director notified 28a-f 1 🗌 Yes 2 🔀 No MD Carro11 Mt. Airy ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be i Funeral 508 Beck Dr. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S.
Armed Forces?
1 ₹ Yes 2 □ No
If Yes, Give
Year or Dates, unknown Black, White, etc. þ 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Divorced 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working of Health and Mental Hygiene. If item 27 is marked other than ir other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) State Police State of Maryland 12 Be filed 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic even once. ဂ Edward Schlotterbeck Isabelle Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Beck Dr., Mt. Airy, MD 21771 Letitia B. Schlotterbeck/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/27/2010 Rest Haven Cemetery Hagerstown, MD 21. Signature of Funeral Service Licen-28 Name and Address of Earlity Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Pa 1. Ente the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death sh ck, or heart failure. List only one cau Immediate Cau e (Final disease or condition resulting in death) Sepsis Ph_sician/ Medical Due to (or as a consequence of): Examiner year Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Examine as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year g Unknown Part II. <mark>Other sîgnificant conditio</mark>ns contributing to death but not resulting in the underlying cause given în Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 No Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner - eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signatur 29d. Date signed Month, Day, Year) 2010

State Registrar

DHMH 17 Rev 7/2009

ark

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

GARUS

31. Date filed (Month, Day, Year)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Marylan	d / Depa	artment of H	ealth and i	Mental Hy	giene	0010
		٠	State Registrar		Cer	tificate of D	eath	1	Reg. No. U U	40313
	Physicia	n/	Decedent's Name (First, Middle, in the control of the control	,				Date of Dea Month	Day Year	3. Time of Death
See.	Medic	al	FLORENCE 4a. Facility Name (if not institution, g			1		DECEMB		
	Examin	er		•	100CC	4b. City, Town, or I	Location of Death .TMDRE		4c. County of Dea	ith
	Funeral		5. Social Security Number	i. Sex 7. Age (In yrs. Ia	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		rthplace (State or Foreign
	Director		217-20-9393	1 □ M 2 🔀 F 84	Yrs.	Months Days	Hours Min.	1-268a)	1926	ountry) MD
	nd how at	٦c	Usual Residence of Decedent 10a. State 10b. County	10c, City	, Town or Lo	cation				10d. Inside City Limits
	faryla Ba-f s tified	Director	MTh	B	altir	nore				1 Yes 2 ☐ No
	the Na or 2	I Di	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	\
	within 72 hours after death with the Maryland rgiene. ter than "natural", or items 23a or 28a-f sho t; the Medical Examiner must be notified at	Funeral	4547 Shan	nrock Avenu		210	306		ust	†
	r deat or iten niner r		11. Marital Status1 → Never Married 2 □ Marrie	12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of His f Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
036	s afte ral", c Exarr	q pe	3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates.		Yes 2 PANo	Specify:		Specify:	Black
21215-0036	2 hours aftunatural", "natural", edical Exar	Completed by	15. Decedent' (Specify only highest		16a. Deced	dent's Usual Occupa	tion	kina	16b. Kind of Business	Industry
12	hin 72 ne. than	om	Elementary/Seconday (0-12)	College (1-4 or 5+)	C life. D	kind of work done du O NOT use etired)	. 1		Leanato	n I adu
	ed wit Hygie other ent, th	Be C	17. Father's Name (First, Middle, Las	st)	- Dave	s repre	18 Mother's Nan	ne (First, Middle,	•	71 Dairy
lan	ould be filed wii d Mental Hygie marked other matic event, th	To	Harry Hawl				Ada	_ Sha		
Maryland	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. ortants: If item 27 is marked other than "natural", or items 23a or 28a-f show ortants: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	3 3	18a. Informant Name/Relationship		19b. Mailir	ng Address (Street ar	nd Number or Pul	ral Route Number	; City or Town, State, Z	ip Code)
	and 2 s Health em 27 ther tra	П	Carolyn Jackson		454			re., Ba	Ho. on	D 21206
Baltimore,	ge 1 and the strategy of the s		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State 20b. P	lace of Dispo emetery, cren	sition (Name of nator) of other place) N	Date	20g. Location - City o	
Ħ	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Lice		butu	shemon	W 12-	23-10	Arbutus	0110
Ba	permit. Departr Importa any inju		Vaugh (T. Greene	5	151 Bat	to. Na:	t'i Pik	meral 5 e (2122	29)
П			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	omplications that caused the death						Approximate Interval Between
	nysician/		Immediate Cause (Final disease or condition	_ a. DE SCENDING	- Aok	THE ANE	uerun /	ENTURE		Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	1.0				
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequ	ence of):					
	rted d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury							
	execu an and rial-tra	EX	that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):					
00	the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical		d						
387	ertifica ding p	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnar	acv					
Box 687	t the death certific by the attending p tached for use as	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 Live Birth 2 Fetal	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
B	the de by the ached	hysi	9 Unknown	9 🗆 Unknown						
Division of Vital Records, P.O.	v requires that is been signed to should be deta	by P	Part II. Other significant condition	s contributing to death but not resu	alting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
ds,	quires en siç ould b	ted	# 4T T					1 🗆 Y	/es 2 □ No 3 💢 F	Probably 4 Unknown
00	law re nas be e 2 sh	Completed						24a. Was a autop	sv prior to	utopsy findings available completion of cause of
Be	sician: The law i certificate has t irector, page 2 s							1 🗆 Yes	rmed? death? 2 ■ No 1 □ Ye	s 2 No
lita	Physician: T r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ED/0-1	Other	ce of Death (Chec			
of \	g Phy er this eral d	e: To	27. Manner of Death		28b. Time of	28c. Injury	at		ence 6 Other (Spectors) Ow injury occurred	city)
on	ending F eath. or: After he funer	ficat	1 Natural 5 Pending 2 Accident Investiga		injury	M 1 □ Y	∕es 2 □ No			
VISI	or Attend ifter death irector: / n by the f	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			eet, factory, office		28f. Location (S City or Town	treet and Number or Ru n, State)	ural Route Number,
Ö	pital ours a eral C	edical (29a. Certifier 1 Certifying P	Physician: To the best of my knowle	adge death o	occured at the time	date and place, a	nd due to the ear	und(n) and manner as at	atod
	the Hospital or hin 24 hours afte the Funeral Dir mpleted filled in	Medi	(Check 2 L Medical Exa	aminer: On the basis of examination	and/or invest	igation, in my opinion	n, death occurred a	at the time, date ar	nd place, and due to the	cause(s) and manner stated.
	To the within 2 To the comple	<	29b. Signature and title of certifier			29c. License			29d. Date signed (Mont	
			1 278			RES	-000		JECEMOER	17,2010
٨			30. Name and address of person wh	o completed cause of death (Item	23a) (Type, F	rint)	44.5		RE, MD	
1)	Stat	0	SEAN TACKE 31. Date filed (Month, Day, Year)	no completed cause of death (Item 49 32. Registrate Signat	70 E	ASTERN	AVE E	BALTIMO.	RE, MD	21224
	Registra	•	DEC 21 2010	Deserry B. 19	arres					

*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 19^{Day} Physician/ Richard Francis Sichelstiel 2010 Dec 7:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth Funeral Days Hours Min (Month, Day, Year) 2-6-1926 1**X** M 2 □ F 214-20-4866 84 Director Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural". or items 23a or 28a.s eh.w. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Carroll Westminster MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 225 Frock Dr. 21157 USA , Apt. 141 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify.white 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Electrical Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Sichelstiel Pearl Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 88 S. Colonel Myers Dr., Martinsburg, Calvin Richardson-son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial 12-22-10 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home Signature of Funeral Service Lie Honas Westminster, MD 21157 Main St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Ven neer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 No cate has been signed by the page 2 should be detached g 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 1 Yes Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? HOS DICE Hospital 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: of the formula in by the formula in by the formula in the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) ello 2010 52035 Dec 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/157 CHA GLO 29 Stoner BIND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) r 19, 2010 Month **Physician** December 10:30 p^M Carolyn Sheppard Η. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore <u>Baltimore</u> Manor Care-Ruxton 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Hours **Funeral** 1 □ M 2 💢 F Months Days 218-01-9542 April 29,1943 Director 67 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 □XYes 2 □ No Director <u>Baltimore</u> Maryland | N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural", or items 23a or other traumatic event, the Medical Examiner must be 21209 U.S.A. 1803 Thornbury Roed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 0 None es 1 and 2 should be filed w of Health and Mental Hygie f Item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မှ <u>Caroline</u> Howard Daniel Heisler Sheppard. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lutherville</u>, Maryland D. Herbert Sheppard Brother <u>24 Seminary Drive</u> permit. Pages 1 a
Department of He
Important: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 12-21-2010 Towson Maryland 21. Signature of Euneral Service Libensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Down **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SNIG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for ea a nonsequence offi-Examine attending physician and for use as the burial-transit fry ilsonyt that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 2 1 No 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident al or Attend after death by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEROAMA

Registrar DHMH 17 Rev 1/2001

State

JAYAM

31. Date filed (Month, Day, Year) DEC 21 2010

dsier

7505

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		-	nt of Healt te of Dea			iene	40316
	4	1	Decedent's Name (First, Middle, L.)	ast)					Date of Deat	h	3. Time of Death
	Physic		Sofia Michelle	Speranzella				De	Month ecembe	er 2 2010	11:00 PM
	/Medi Examir		4a. Fecility Name (If not institution, ga			4b. City	, Town, or Locat	ion of Death		4c. County of Deat	
			Greater Baltin	nore Medical	Cent	er	Tows			Baltim	
1	Funeral			Sex 7. Age (In yr	rs. last birthda Yrs.	Months	Days Hou	ırs Min.	Date of Birth (Month, Day,		hplece (State or Foreign ountry)
3	Director		Usual Residence of Decedent	-X-	Yrs.		3	10	12/02/1	LO MI)
1	aryjand show		10a. State 10b. County	10c. (City, Town or	Location					10d. Inside City Limits
1	Mary First	tor	MD Baltimo	re	Notti	ngham					1 ☐ Yes 2☐ No
\	ith the N or 28e-f	irec	10e. Street and Number			10f. Zi	p Code		11	0g. Citizen of What Co	ountry?
RO	036 urs after death with the Maryla et', or trams 23a or 28e-1 shov Examiner must be notified at	ai D	134 Sipple Ave.				21236			U.S.	
Z Z	ter death w Items 23e	nei	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1	 Was Dece If Yes, spe 	edent of Hispanio	Origin? (Specifician, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	
B	36 safte	y Ft	1 Mever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 2 X No If Yes, Give Year or Dates:		1 🗆 Yes	2□ No Spe	city:		Specify: Wh:	ite
5	72 hours	ed t	15. Decedent's		16a. De	cedent's Usi	al Occupation			16b. Kind of Business	
3	715 nin 72 n ne	piet	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(G	ive kind of w e. DO NOT	ork done during	most of working			·
7	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "naturet", or itams 23a or 28e-1 show ont, the Medical Examinar mant be notified at	Completed by Funeral Director	O O	O (1-401 3+)		Infant				Infant	
	be filed hall Hyging of other event, in	Be (17. Father's Name (First, Middle, Las	it)						Maiden Sumame)	
>	Aarylanc 2 should be f and Mental H 1s marked ot raumatic ever	o	Stephen Speranz					Sandra			
4	re, Maryland s 1 and 2 should be file f Health and Mental Hy ltem 271s marked oth other traumatic event	1 3	19a. Informant's Name/Relationship							; City or Town, State, 2	
	- 650 -		Greater Baltimor 20a. Method of Disposition		. Place of Dis	sposition (Na	me of	Date		MD 21204	
W	O 0		1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, c	rematory or	other place)	 			
13	Baltimore, permit. Pages 1 at Department of Hea Important: If Item any injury or othe once.		*4 □ Donation 5 ▼ Other (Spectal Service Lice Ronal Service Service Lice Ronal Service Servic			22. Name a	nd Address of F	acility Poored 6	55 U	Baltimore	Stroot
1	n 82558		23a. Parit. Enter the disease, or co	111111	13	Baltim	ore, MD	21201			'
	Dharisian		shock, or heart failure. List onl	y one cause on each line.	sath. Do not).	8	n as cardiac of fi	espiratory arre	951,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons	sequence of):	11/4/	natur	rug	0	ė	
	Examiner		Comment of the first area distance		3 fw	6	runt	ure la	Y W	rembusi	ies
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):		i litte		}		
	60, be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to for as a cons		MIC	MITO				
	68760, tificate be ex ig physician as the buria										
	687 filicate g phys	edic									
	Box 68 leath certific attending pl	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		3 □Ectopic ;	reanancy			23d. Date of de	,
	t, P.O. BC that the death ned by the atter	by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☒ No	4 Pregnant at time of		5 Other (s				Month	Day Year
1	P.C	Phy	9 Unknown		andian's the	aadaut.iaa		No. of I	22a Did tol	bacco use contribute to	o the cause of death?
	DIVISION OF VITAL RECORDS, P.O. I or Attending Physician: The law requires that the after death. Director: After this certificate has been signed by the funeral director, page 2 should be detached in by the funeral director, page 2.		Part II. Other significant conditions	contributing to death but not in	resulting in the	e underlying	cause given in F	art I.			robably 4 Unknown
	w req	Completed				-			24a. Wasa	ın 24b. Were a	utopsy findings available completion of cause of
1	r Vital Rec ysicien: The lav is certificate has director, page 2	omp							autops perforr	med? death?	completion of cause of
	VITAL FIGURE THE CERTIFICATE PROPERTY P	BeC	25. Was case referred to medical				26. F	Place of Death (0			
,	Of V Physic this ce al direc	ToE	examiner? 1 ☐ Yes 2√∑ No	Hospital: 1 ☐ Inpatient 2		tient 3 🗆 🗅	OA Other: 4[Nursing Home	5 🗆 Reside	ence 6 Other (Spe	icify)
	On Of ding Phy h. After thi tuneral (27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Timi	ry	28c. Injury at Work?		d. Describe ho	ow injury occurred	
	Vitendia death. ctor: A y the fu	cati	2 Accident investigate 3 Suicide 6 Could not	he -	1 hama far-	M	1 🗆 Yes		Location /St	treet and Number or R	ural Pouto Number
	DIVISIC pital or Attencours after death neral Director: filled in by the	Certification:	4 ☐ Homicide determine	28e. Place of Injury - At building, etc. (Spe	icify)	street, facto	гу, опісе	201	City or Town	n, State)	siai noute ivuilber,
	DIVISION Of VITAL RECORDS, P.O. BOX 68/6U, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the best of my k aminer: On the basis of exami and manner stated.	knowledge, de ination and/o	eath occurre r investigatio	d at the time, dat n, in my opinion,	te and place, and death occurred	d due to the ca at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	within To the compl	₩	29b. Signature and title of certifier	1 11		29	c. License num	ber	2	9d. Date signed (Mon	th, Day, Year)
			1 18/12	115 MAI			171	1009		12 2	10
			30. Name and address of person wh							07.004	
	48		Marwan Hajj,	M.D. 6701 82. Registrar's Sig		narle	es St.,	, Towso	on, MD	21204	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 21 20	10 Senetar s sig	1. Sa	Mas					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AURERT Month 12 DORRECHTINO 2010 9 50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death **Baltimore** Stella Maris Timonium 6. Sex 1 **X** M 2 □ F 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours Maryland Director 214-16-9815 88 Nov 1922 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland **Baltimore** Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1911 Cranbourne Road 21093 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", 3 X Widowed 4 Divorced Year or Dates White any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than a Elementary/Seconday (0-12) College (1-4 or 5+) n/a **Plasterer** Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Torchia Charles Sorrentino Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 Cranbourne Road, Timonium, MD 21093 Susan M. Klein/Daughter A.M. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 12/20/10 Baltimore, Maryland 10W. Madonial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bryan W. Clarcy Mol. emman Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final errior monary Ph_sician/ Medical resulting in death) Due to (or as a consequence of): mintel **Examiner** DU WHOM 12 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on sician and burial-transit Myo cardip Due to (or as a consequence of): resulting in death) Last Weaters Physician/Medical DECEMBER 16 that the death certificate be inactes Box 68760 as the t IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Sknosis Sevele Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed page 2 should huge chlestortemia SORRENTINO 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? FA. live Chronic Renal certificate Yes Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 M Nursing Home 5 - Residence 6 - Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14 Natural work? 5 Pending 4LBERT 2 🗌 No Investigation 6 Could not be within 24 hours after death To the Funeral Director: / Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one

State Registrar 29b. Signature and title of certifie

(charco

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W>

atter of

Dulanen

2300

32. Regetrar's Signature

29c. License number

D31926

29d. Date signed (Month, Day, Year)

21093

12/16/2010

MO

TIMONIUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State	State o	f Marylar		artment of H		and M	ental Hygi	iene	aln	1.0210
			Registrar 1. Decedent's Name (First, Middle,	(act)		Cer	rtificate of Death				Reg. No.		
	Physicia	ın/		BEATRICE	· CIII	LIVAN				2. Date of Death Month December	Day _	OÎÔ	3. Time of Death 10:48a M
	Medic Examin		WILLIE 4a. Facility Name (if not institution,	4b. City, Town, or	r Location o		December	4c. County		10:40a ···			
	*	ICI	5413 NELSON AV		,			IMORE			N/		
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under Hours		8. Date of Birth	Voor	9. Birth	place (State or Foreign
	Director		220-36-1804	1 □ M 2 X F	7	2 Yrs.	IVIOITIIS Days	Hours	IVIIII.	MAY 8 1	938	MARY	LAND
	nd how at	=	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Loc	cation					1	0d. Inside City Limits
	laryla 3a-f s iified	Director	MARYLAND N/	4			BALTIMO	ORE					XX Yes 2 □ No
	or 28	۵	10e. Street and Number	-			10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
	s 23a	Funeral	5413 NELSON	AVENUE			212	215			U.S	.A.	
	death item	Ψ	11. Marital Status	Armed For			Vas Decedent of H f Yes, specify Cuba	ispanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)		e - Americ	
36	after al", or xami	d by	1 Never Married 2 Marri 3 Widowed 4XXDivorced	If Yes, Giv	Э	1	☐ Yes 2XXNo	Specify:				BLAC	
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed	15. Deceden		ies.	16a, Deced	lent's Usual Occup	ation		T	16b. Kind of B		
215	in 72 e. nan "r Med	dmo	(Specify only higher Elementary/Seconday (0-12)	st grade completed) College (1-	4 or 5+)	(Give F life. D	kind of work done of NOT use retired)	during most	t of workin	g			,
	I within ygiene.		12th grade	2yrs		HEAL	TH CARE	AID WO	ORKEF		ROSEWO	OD HO	SPITAL
Maryland	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, La	ast)						(First, Middle, M		e)	
Ĕ	should be file n and Mental H 7 is marked o raumatic eve	-	FRANK GRAVES 19a. Informant's Name/Relationsh	in /Time Print)		1401 14 15	A I I (O)			E GRAVE		Dist. 70- 0	2-41
Ma	2 ± 2 ±		Vincent R. Grave			1	g Address (Street a						Jode)
ē,	e 1 and t of Heal If item 3		20a. Method of Disposition			Place of Dispo	sition (Name of				20c. Location		own, State
<u>m</u>	Pag nen ant: Iny		1 ☐ Burial 2XXCremation 4 ☐ Donation 5 ☐ Other (S)		State		natory or other plac EMATORY		12-20)-10	BALTIM	ORE,M	ARYLAND
Baltimore,	permit. Page Department Important: I any injury o		21 Signstore of Funeral Service Li	te dee		22 V T	. Name and Addre: LLIAM C]	ss of Facility RRAWN	COMM	HINTTY F	IINERAT.	HOME	РΔ
	20 E 8 9		Marlour G	1		1	<u>206 W NOI</u>	RTH A	VENUE		<u>"</u>	110111	1.11.
ш			23a. Part 1. Enter the disease, or shock, or heart failure. List or immediate Cause (Final	complications that only one cause on ea	aused the deat ch line.			g, such as	cardiac or	respiratory arres	st,		Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	a	UGNA		eoplas	m c	1	hary	NX	-	year
	Examiner		Due to (of as a consequence of).									Ü	
	7	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (of as a sonseq	usnes or):						30	
	outed nd ransit	Examiner	Cause (Disease or iinjury that initiated events	c									
	Attending Physician: The law requires that the death certificate be executed or decth. ector: After this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit	alE	resulting in death) Last	Due to (or as a conseq	uence of):							
760	physic the b	edical	`	d									
68760	ath certific attending p I for use as	Ň	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of <u>pr</u> egna	ancy _					23d Da	ite of delive	en/
Вох	eath o	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4 Pregr	ant at time of		Ectopic pregnand Other (specify)	СУ				onth	Day Year
O.E	that the des ned by the s detached f	hys		9 🗆 Unkn									
P.O.	w requires that s been signed t should be deta	by	Part II. Other significant condition	ns contributing to de	eath but not res	sulting in the u	nderlying cause giv	ven in Part I	l.	1			ne cause of death?
rds	een si ould I	Completed	- DINDET			-				1 ∐ Ye			pably 4 🗹 Unknown
000	has b je 2 st	mple	Hyper	TWIS	(OV)					24a. Was an autopsy perform	/ /		psy findings available mpletion of cause of
R	ician; The la certificate ha rector, page		25. Was case referred to medical			····				1 🗆 Yes 2		1 🗌 Yes	2 □ No
/ita	ysician; is certific director,	o Be	examiner? 1 Yes 2 No	Hospital:	tit 0 [EB/O: to obtain	Oth	ace of Deat		1			
of Vital Records,	ding Phys th. After this funeral di	e: To	27. Manner of Death	28a. Date	Inpatient 2 of injury	28b. Time of	28c. Injun	y at		ne 5 Resider 8d. Describe hov)
u	tter ding dec th. stor: Aft. / th. fun	ficat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investig	ation	h, Day, Year)	injury	M 1 🗆	Yes 2	No				
Division	r Atte er de irecto by th	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e. Place	of Injury - At hog, etc. (Specify	ome, farm, stre	et, factory, office		2	8f. Location (Stre		er or Rural	Route Number,
	Hospital or 24 hours a 6 Funeral Din sted filled												
	To the Hospital or Attendi within 24 hours a er det.th. To the Funeral Director: A completed filled by th. ft.	Medical	(Check 2 Medical Ex	Physician: To the be caminer: On the bas Nurse Practioner: 1	s of examinatio	n and/or invest	igation, in my opinio	on, death oc	ccurred at 1	he time, date and	place, and du	e to the car	use(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier		o the best of fil	, mowieage, a	29c. License		and place		d. Date signed		
			1 Tonce	2 LVA	M	MD	123	703	36		050	12	117/2010
0			30. Name and address of person w	ho completed caus	e of death (Iten	23a) (Type, P	rint)		200	DC =	1-01	20-	mo
<i>y</i>			31 Data filed (Month Day Your)	TVAV	15 M		4538	DIN N	IUN	USON.	The !	754	111030X
	Stat	e	31. Date filed (Month, Day, Year)	A 32. Re	egistrar's Signa	ture A Na	1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Ī5, Virginia A. Stilling 2010 2:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 5153 Westland Blvd. Baltimore 8. Date of Birth May 8, 1938 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛣 F Min. Months Hours 212-34-0828 72 Maryland Director Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Baltimore Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21227 United States 5153 Westland Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian Black, White, etc ð 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Waitress Restuarant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Edward White Anna ukn 19b. Mailing Address (Street and Number or Fural Floute Number, City or Town, State, Zip Code) 5153 Westland Blvd., Baltimore, MD 21227 19a. Informant's Name/Relationship (Type, Print) Terry A. Kolarek - Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Most Holy Redeemer Cemetery Dec.20,2010 4 Donation 5 Other (Specify) Baltimore, MD Service Licens Marme and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ bouzmare 3 Hilaus disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury for use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No been signed by the should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 shoult 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical

State Registrar

29a. Certifier

(Check

only one)

3 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

REC 2 1 2010

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regisfrar's Si

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

12-15-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 10320 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Smith 3:39 AM **Physician** December 10 2010 Argoe Naig /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 X F Delaware 81 Director 222-20-2426 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 No Director must be notified Reisterstown MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 21136 Funeral 801 Holly Hill Court 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ If Yes, Give 3 ☐ Widowed 4 🕅 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Marvel ည Lloyd Fisher Argoe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 801 Holly Hill Court, Reisterstown, MD 21136 Daughter Kristi Smith 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of h Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 12/16/2010 Middletown, DE 4 Donation 5 Other (Specify) Forest Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 enper Eline Funeral Home ner 23a. Part 1. Enter the isease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hemorrhagic **Physician** /Medical Due to (or as a consequence of): **Examiner** aneurysm rupture middle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 2 No 2 Accident Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only

State Registrar

31. Date filed (Month, Day, Year, 2010 DEC 21

Winsofe

Jamie

29b. Signature and title of certifier

one)

32. Registrar's Signature parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES- OCC

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

December 10,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Marylan	•	artment of He <i>tificate of De</i>		lental Hygie/ Reg.	2010	40321
П	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Medic		Jean Marie	Skipper		4b. City, Town, or L		December	16, 2010	9:05am м
	Examin	er	4a. Facility Name (if not institution, give s	4c. County of Death						
	Funeral		Golden Living Ce 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	stminste If Under 24 Hrs.	8. Date of Birth	9. Birth	pplace (State or Foreign
	Director		212-20-2832	M 2 X F 81	Yrs.	Months Days	Hours Min.	April 29,	1929 Cou	ntry) MD
	how how at	r	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits
	laryla 3a-f s iified	ecto	MD Carroll		Finks	burg				1 ☐ Yes 2 🛣 No
	the N	ΙDir	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?
	n with	Funeral Director	2551 Baltimore	Blvd. Lot 7	6	21048	8		USA	
	r item		11. Marital Status 1 X Never Married 2 ☐ Married	 Was Decedent Ever in U.S Armed Forces? 		Vas Decedent of Hisp Yes, specify Cuban,			14. Race - Ameri Black, White,	
036	s after al", o Exam	d by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2🌠 No If Yes, Give Year or Dates.	1	☐ Yes 2🌠 No	Specify:		C-00%	White
2	hour hatul	olete	15. Decedent's Edu (Specify only highest grad	cation		lent's Usual Occupation		161	b. Kind of Business Ir	
21215-0036	hin 72 ne. than '	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	kind of work done dur D NOT use retired)		·	D11- C D	1
р С	ed wit Hygie other	BeC	12 17. Father's Name (First, Middle, Last)		<u>F</u>	actory Wor		e (First, Middle, Maid	Black & De	ecker
au	be fillental	욘	Philip Skipper			'	Agnes		ien Sumame,	
Maryland	2 should be filed within 72 th and Mental Hygiene. 17 is marked other than " traumatic event, the Mec		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street and	d Number or Rura	l Route Number, City	y or Town, State, Zip	Code)
Σ.	ealth m 27		Lee Griffith	Executor	2551	Baltimor	e Blvd.	#71, Fink	sburg, MD	21048
ore	Je 1 a It of H If ite or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F		ace of Dispos metery, crem	sition (Name of natory or other place)	i		c. Location - City or T	own, State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			Memorial		0/2010	Parkvil:	
Ba	permi Depar Impor any ir		21. Signature of Pulleral Service License	2		Name and Address			Reistersto rstown, M	
١			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the death	. Do not ente	r the mode of dying,	such as cardiac o			Approximate Interval Between
1	nysician/		Immediate Cause (Final disease or condition	metalatio		reast (12	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	. Due to (or as a conseque	ence of):					
	d ansit	Examiner	Cause (Disease or iinjury that initiated events						1	
	exectian an	E	resulting in death) Last	Due to (or as a conseque	ence of):					
90	icate be executed physician and sthe burial-transit	edical								
687	certific iding R	M/M	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregnan	icy				22d Date of delis	
Box	eath o	Physician/M	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fetal		Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year
O. E.	the d by the tacher	hys	g 🗆 Unknown	g 🗀 Unknown						
<u>. </u>	es tha	ρ	Part II. Other significant conditions con	tributing to death but not resu	Ilting in the ur	iderlying cause given	in Part I.		co use contribute to t	he cause of death?
rds	requir	etec								opsy findings available
eco	e law e has l ge 2 s	Completed						24a. Was an autopsy performed	prior to co	mpletion of cause of
<u>m</u>	an: Th tificat tor, pe	Be	25. Was case referred to medical			26. Place	e of Death (Check	1 Yes 2	No 1 ☐ Yes	2 L No
\ <u>\frac{1}{2}</u>	hysici nis cer I direc	To E	1 L Yes 2 No	ospital: 1 npatient 2 E	R/Outpatien	t 3 DOA Other:	4 Nursing Ho	me 5 🗆 Residence	6 Other (Specify	y)
סר	ing P	ate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	_	28d. Describe how in	njury occurred	
SIOI	Atteno death ctor; y y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor	ne. farm. stre		s 2 No	28f Location (Street	and Number or Rura	l Route Number
Division of Vital Records, P.O.	al or / s after il Dire		4 ☐ Homicide determined	building, etc. (Specify)		, , ,	l.	City or Town, St.		, riodic (vallibo),
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	ian: To the best of my knowle	dge, death o	ccured at the time, da	ate and place, and death occurred at	d due to the cause(s)) and manner as state	ed. ause(s) and manner stated.
	the ithin 2 the omplet	×	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of my	knowledge, d	eath occurred at the til	me, date and place	e, and due to the cau	se(s) and manner as so Date signed (Month,	tated.
	F≯¥ŏ		Administrations	Ulita Man		7.54	442	/ 290.	11.12	July, reary
			30. Name and address of person who con	npleted cause of death (Item	23a) (Type, Pa	rint)		1/9	7 4 4 40	
			John W. Middle	eton M.D C	e88 i	Poole R	d, Wa	Sommete	MD	31157
	Stat Registra	e Ir	31. Date filed (Month, Day, Year) DEC 2.1 2010	32. Registrar's Signatu	arked				1	·
				4-1-1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 5:30 am 201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A SINAI HOSPITA BALTIMORE 8. Date of Birth 9. Birthplace (State or Foreign Country) POLAND Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Months Hours Min. 1**)(**X) M 2 □ F Director 214-23-3193 95 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD **BALTIMORE** N/A XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6956 MILBROOK PARK DRIVE, #1A 21215 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2XX No Specify. Specify: 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) BAKERY F00D Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Mental ည SMOLKIN GITTEL LEVIN . Page 1 and 2 should b ment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 LIVELY STONE COURT BALTIMORE, MD 21209 DMITRY SMOLKIN/SON other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott Burial 2 Cremation 3 Removal from State ARICTUGTON CEMETERS BALTIMORE, 12/19/2010 Donation 5 Other (Specify) ON & BROS., PIKESVILLE, 22. Name and Address of Facility SOL LEVINSON 8900 REISTERSTOWN ROAD, PIK INC. MD 21208 Signature of Funeral Service Licenses Scett 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner elva Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iiniury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown completed filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 8 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, gill, Department of Health and Mental Hygiene Certificate of Death Reg. No. for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 07:16AM lam immons Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tarbor Stimore tosai If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🕅 M 2 🗆 F Months Days Hours Min. (Month, Day, Year ug 30 Mary Land 212-30-5211 1027 Director 83 Aug Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Linthicum Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code Funeral 38 Eleanor Avenue 21090 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian unk Armed Forces Black, White, etc. δ 1 Never Married 2 Married X Yes Yes. Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Completed 3 Widowed 4 Divorced 46-48 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 0 transportation bus driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Katherine Merson Norman Samuel Timmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Eleanor Avenue Linthicum, MD 21090 Constance A. FAlls/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature of Euneral Service Board 655 W. Baltimore Street Kertor Baltimore. MD 21201 23a. Part v. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 20 minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death signed by the a d be detached for 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an • Hospital or Attending Physician: The law r 24 hours after death.
• Funeral Director: After this certificate has b certificate has b lirector, page 2 s autopsy completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? hay to Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes Certificate: 28d. Describe how injury occurred 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 3001 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	rtificate of		u wen	arriygic		g. No. 20		032
Physicia	an/	Decedent's Name (First, Middle,Last)	т	homnec	'n		te of Deat	1	ar	3. Time of Death
Medical Exami	ner			hompso			cember	17, 2010		2150 hrs
		Facility Name (if not institution, give street and number) Baltimore Washington Medical Center	4						or Death undel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthp								
Director	[Foreign									
		Usual Residence of Decedent		L						
, any			, Town or Locatio	icott	City	7				10d. Inside City Limits
Maryland 28a-f show d at once.	ō	MD Howard			СІСУ					1 Yes 2 XNo
Mary r 28a- cd at	Director	10e. Street and Number		10f. Zip Code	L043		10	g. Citizen of Wh	at Cour	ntry?
ith the Maryland 23a or 28a-f sho notified at once.	_	3319 Govenor Martin Ct.	0 140 144				Д.			
ath wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		Decedent of His s, specify Cubar					- Americ e, etc.	can Indian, Black,
fter de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 X No	specify:			Specify:	B1:	ack
ours at atural	d by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent'	s Usual Occupa	tion (Give k		one	16b. Kind of Bu	siness/Ir	ndustry
6 172 he	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)		st of working life		use retired)		Infor		
withir iene.	Ĕ	12th grade 4yrs	D:	irecto						9 Y
15-	Be C	17. Father's Name (First, Middle, Last)				an Bro		aiden Surname	,	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	일	Joseph Morton Sr. 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Stree				per, City or Tow	n, State.	Zip Code)
MD and 2 sho ulth and no 27 is sumati	٦	Marc Thompson-Husband								City04Md
re, l l and l Healt fitem		20a. Method of Disposition 20b. I	Place of Disposit	on (Name of cer		Date		20c. Location -		
Pages nent of			butus		al I	12/23,	/201) Arb	utu	s, Md
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. 3 gnature of Funeral Service Licensee	22 Na	me and Address	of Facility	s t	- 123			0.3.0.3.5
		Dornald C. Gright	43	00 Wab	ash A	Ave,				
Physician		23a Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.		mode of dying,	such as ca	rdiac or respi	ratory arre	st, shock, or hea	art	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Cardiac Sard Due to (or as a consequence or								Death
		Sequentially list conditions, b	.,.							
July .	<u>a</u>	if any, leading to immediate cause. Enter Underlying Cause	f):							
Ux.	Examiner	(Disease or hijury that initiated events resulting in death) Last Due to (or as a consequence or	f):							
		d								
60, ate be execute hysician and e burial - trans	Medical		ME G91	1 1/11/1	11 MAN	M				
	N.	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the		I death 3	Ectorio	pregnancy		23d. Date of		av Year
Box 687 e death certific the attending ped for use as the		past 12 months? 4 Pregnant at time of de	-th -	Ideath 3 [er (S <i>pecify)</i>	Lotopic	pregnancy		Month	b	ay Year
Box 687 ne death certific the attending p	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown								
P.O. s that the	P P	Part II. Other significant conditions contributing to death but not re	esulting in the un	derlying cause g	given in Parl	t I. 2	3e. Did tob 1			he cause of death?
S, P.C.	peg					— <u> </u>	4a. Was a			ably 4 Unknown opsy findings available
law recharged by the second se	ple						autops perform	у р		ompletion of cause of
tal Rection: The Certificate ector, page	Completed						✓ Yes 2		✓ Yes	s 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpationt		Othor	Nursing Hom		esidence 6	Other:	
of V ing Phys After thi	의	1 Yes 2 No Impation 2 27. Manner of Death 28a, Date of Injury	28b. Time of Inju	0 001	ry at Work?			w injury occurre		
OD OD ath.	ţiol	1 X Natural 5 Pending (Month, Day,Year)		1 🗌 Y	res 2 🗌 t	No				
VISI or Att fler de Directe	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At ho	ome, farm, street,	factory, office b	uilding, etc.				r or Rur	al Route Number, City
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as it	Certification:	4 Homicide determined (Specify)					Town, Sta	ite)		
To the Hos within 24 h To the Fur completely		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowleds one) 2 Medical Examiner: On the basis of examination and one of the basis of the basis of examination and one of the basis of t								
To the To the Comp	Medical	29b. Signature and title of certifier	nd/or investigatio	29c. License		uned at the ti		29d. Date signe		
		La V: / I to S		O.C.I				December 1		
7	ŀ	30. Name and address of person who completed cause of death (Item	23a)	1 3.5.1						
V			Penn Street,	Baltimore, I	MD 2120)1				
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ire							
Regist	rair	DEC 2 1 2010 2 de 1	ackel					-		
DHMH 17 Rev 1/20 OCME 2006	01		ORIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Tuite 12:03 PM Lorraine Stacy 2010 Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimer Hospite If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 21 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign ^{Year)} 19<u>28</u> Days 1 M 2 1 F Months Hours Min. Director Yrs 217-24-0761 82 Marvland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must be actived a second 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Baltimore Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 8208 Laurel Drive 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 State of Maryland Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Kentner, Sr. Henry Charles Annie. Stacy Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9009 Perring Park Road 21234 William J. Bender Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Dother (Specify) Baltimore Maryland Gardens of Faith 21. Si Fune I Setvice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Maryland 21204 Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Shock disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Wound Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No မ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Mann of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural iniury 5 Pending ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 88191579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sina HOSPILL MiD Date filed (Month, Day, Year DEC 21 2010 32. Registrar's Signature State rack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 9:05 Kokert Veillette JD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PK 5. Social Security Number Hearth Anne Arundul ern Date of Birth (Month, Day, Yea Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Country) 1**XX**M 2□ F Days Hours Min JULY 3, 84 Director 217,22,2370 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar and injury or other traumatic event, the Medical Examinar and injury or other traumatic event, the Medical Examinar and injury or other traumatic event, the Medical Examinar and any injury or other traumatic event, the Medical Examinar event, the Medical Examinar events. 10c, City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2☐ No Director **PASADENA** MD ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7613 BAY ST. Completed by Funeral 21122 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If XXs, Give Year or Dates: 2 □ No 1 ☐ Yes XX No Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **ELECTRONICS TECHNICIAN** CHEMICAL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be REGINA CLOUTIER WILFRED VEILLETTE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSALIE VEILLETTE WIFE 7613 BAY ST. PASADENA, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐Removal from State **GLEN HAVEN CEMETERY** 12.13.2010 4 ☐ Donation 5 ☐ Other (Specify) GLEN BURNIE, MD 21. Signature of Funeral Servi 22. Name and Address of Facility
FINK FUNERAL HOME, P.A 426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 23a. Part i. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Hist only one cause on each line. Immediate Cause (Final **Physician** preumonia disease or condition resulting in death) days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 687607 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 🔲 Inpatient nours after death.

neral Director: After this y filled in by the funeral di 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12-10-10 D50725 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)
DEC 2 1 2010

32. Registrar's Signature

Hay M. Uersville, MD 21108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

		1 - State Registrar		Cer	tificate of l	Death	,	Reg. No.	U	40327
Physic	1. Decedent's Name (First, Middle, Last) Physician/ Irma M. Wilmoth							ath Day	⁄ear	3. Time of Death
Me	dical				4. 05. 7	- Landing (D. 11)		/18/2010		11:30art
Exan		Future Care Canto	on Nursing Hor		Balti	r Location of Deatl MOTE MD		4c. County of	Death N	/A
Funer Directo	or	5. Social Security Number 212–36–3269 6. Security Number 1 [7. Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date of 20/1	th ly, Yea <i>r</i>) 1922	9. Birthpl Countr	ace (State or Foreign y) MD
and show	ō			y, Town or Loc					10	d. Inside City Limits
e Mary r 28a-f notifie	Director	MD 10e. Street and Number	N/A			ore City				1XXYes 2 □ No
th with th ns 23a o must be	Funeral	940 S. Lakewood			10f. Zip Code	21224		10g. Citizen of Wh	at Count SA	γ?
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	Completed by Fu		12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒☒o If Yes, Give Year or Dates.	If	Vas Decedent of H Yes, specify Cuba	ispanic Orlgin? (Span, Mexican, Puert	oecify Yes or No- o Rican, etc.)	14. Race - Black, Specify:	America White, et	tc.
215- 172 ho an "na Medic	mple	15. Decedent's Ed (Specify only highest grad	de completed)	(Give k	ent's Usual Occup ind of work done (O NOT use retired)	ation during most of wor	king	16b. Kind of Busi	ness Indu	ıstry
within giene.	ပိ		College (1-4 or 5+)		Homemak	er				Own Home
Maryland 21215-0036 12 should be filed within 72 hours affer the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	To Be		1			18. Mother's Nar	ne (First, Middle, Ruth	Maiden Surname)		Unk
re, Marylanc I and 2 should be file I Health and Mental I tem 27 is marked o		19a. Informant's Name/Relationship (Typ. Raymond C. V						r, City or Town, Stat		
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		20a. Method of Disposition 1 3 3 4 □ Donation 5 □ Other (Specify)	Removal from State	emetery, crem Ledar H	sition (Name of latory or other place ill Cem.	12/	Date 22/2010	20c. Location - Ci	æ,M	
Baltimo permit. Page Department Important: It	olice.	21. Signature of Funeral Service License	Victor Doda	^{22.} Ch 15	Name and Address L.	ss of Facility Stevens	Funeral	Home, Ir	nc.	
Physician		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	n. Do not enter	r the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Medica	af	disease or condition resulting in death)	Die to (or as a consequ	ence of):	Doctor	Corney C	Marler (2	reare	14	real.
o tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):						
760 cate be executed physician and the burial-transit	I Exar	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):								
8760 rtificate be ing physic e as the bu	Medical		d						\perp	
Box 68 death certific re attending ed for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnal 1 □ Live Birth 2 □ Feta 4 □ Pregnant at time of d g □ Unknown	I death 3 🗌	Ectopic pregnand Other (specify)	у		23d. Date of Month		y Day Year
P.O.	y Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	iderlying cause giv	ren in Part I.	23e. Did to	bacco use contribu	ite to the	cause of death?
ds, quires en sign	ted b	Bollous Pomphy or	4				1 🗆	Yes 2□No 3	☐ Proba	ably 4 hknown
/ital Recor sician: The law re s certificate has be lirector, page 2 sh	mple	Appo pan acquire		-			24a. Was autor perfo	rmed? 🖊 dea	ith?	y findings available pletion of cause of
an: Th tifficate tor, pa	Be Co	25. Was case referred to medical			26. Pla	ace of Death (Chec	1 🗌 Yes	2 No 1	Yes 2	□ No
Vita nysici nis cer direc	일	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 I	ER/Outpatient	Othe	r.		lence 6 🗆 Other (Specify)	
on of nding Pl ath. : After the e funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆	at		ow injury occurred		
Division of Vital Records, P.O., To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	I Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)		et, factory, office		28f. Location (S City or Tow	treet and Number c n, State)	or Rural R	oute Number,
he Hospi iin 24 hou he Funer	Medical	(Check 2 L. Medical Examine	cian: To the best of my knowled or: On the basis of examination Practioner: To the best of my	and/or investig	aation. In my opinic	 n. death occurred a 	at the time date a	nd place, and due to	the caus	e(s) and manner stated
vith voith com		29b. Signature and title of certifier	4.0		29c. License	-		29d. Date signed (N		
		Melene Sterson		00 \ T = -	D196	0)		12-20-2	2010)
		30. Name and address of person who co				Glev Bur	in Man	land 210	61	
St Regist	ate rar	31. Date filed (Mentil, Day, Yea 2010	32. Registrar's Signatu	- 4	19					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last)
Edward Williams 2. Date of Death 3. Time of Death 1<u>2/18</u> Physician/ 3:17pm M Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Baltimore City Examiner 623 E. Clement Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 216-50-7719 Month Day, Yes Director Usual Residence of Decedent f show 10a. State Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Will. N/A 28a-f Baltimore 1 X Yes 2 ☐ No 10e, Street and Numbe ŏ 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 623 E. Clement Street 21230 USA or items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2**X** No be filed within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: id Mental Hygiene. marked other than "natural", matic event, the Medical Exa If Yes, Give White 3 Widowed 4XXDivorced Specify: Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Construction 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dell Williams Lilly Unk permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Williams / Son 3809 Annapolis Road, Baltimore MD 21227 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2010 Hanover MD 22. Name and Address of Facility
Charles L. Stevens Funeral Home, 1
1501 F. Fort Avenue, Baltimore MD 21. Signature of Funeral Service Licensee Victor Doda ا د 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Cardiovas Cular disease or condition resulting in death) Thero sclerotic Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed COYMary and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician at the burial-Physician/Medical betty P.O. Box 68760 attending p use as IF FEMALE: s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown the g Unknown been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed diance 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has I autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home SAResidence 6 Other (Specify) Hospital: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation within 24 hours after death

To the Funeral Director: of completed filled in by the 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifier 29c. License number Internal 29d. Date signed (Month, Day, Year) D0058858 Medicine, M.D. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kalpana Atluri, MD 3001 South Hanover Street, Baltimore MD 21225

State

Registrar

31. Date filed (Month, Day, Year)

67

Parke

327 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Willie Waddell Day Month Year December 30° 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Randallstown Baltimore Northwest Hospice . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1**XX**M 2 □ F Hours (Month, Day, Year) 03/15/1941 Director 69 <u> 251–68–1239</u> South Carolina Usual Residence of Decedent 3a or 28a-f show be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PG Hyattsville 1 🛚 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral er than "natural", or items 23a the Medical Examiner must b 7801 Barlowe Road #113 20785 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Worker Private Be other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Waddell Birgie Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, "Lampton - Georgia 30228 19a. Informant's Name/Relationship (Type, Print) Janice Shaw/ Daughter 11178 Genova Terr.; Hampton, Georgia Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hills Cemetery 12/22/2010 | Suitland, Maryland 21. Signatur of Funeral Service Licen 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. cancer Immediate Cause (Final Prostate Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be execute signed by the attending physician and dbe detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform performed / Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 🗹 No 4 □ Nursing Home 5 □ Residence 6 ☑ Other (Specify) ျှ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA this funeral ก 24 hours atter นธฉ.... ne Funeral Director: After th inleted filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 115 Ray apatre M.D 29d. Date signed (Month, Day, Year) D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-5-203-Balthmore, MD. 212 09

State

Registrar

N-S. Rajapakse MD

31. Date filed (Month, Day, Year)

racks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 2:15 8m Anthony Williams

4a. Facility Name (If not institution, give street and number) 12-14-2010 /Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 3925 Greenmount Ave If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 X M 2 □ F Director 212-80-7159 47 09 08 63 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evan men must be notified at Director Y☐Yes 2☐No Baltimore MD NA 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 3925 Greenmount Ave 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 21XNo Specify: þ Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Giant Food Market 12th grade Stock Clerk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin Madden Mary Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Williams-Mother 2807 Seamon Ave, Baltimore, Md 21225 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M Burial 2 Cremation 3 Removal from State Arbutus Memorial 12/21/2010 Arbutus, Md 4 □ Denation 5 □ Other (Specify)

21. Signature of Funeral Service License nature of Funeral Service Licensee 22 Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Patt1. Enter the Asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart if ure. List only one cause on each line. Approximate Interval Between Onset and Death End Stayo

Due to (or as a consequence of): End **Physician** 7 months disease or condition /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician ospital or Attending Physician: The law requires that the death certificate be en hours after death.

Juneral Director: After this certificate has been signed by the attending physiciar. Physician/Medical 200 Since IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

5010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. AUNG

32. Registrar's Signature

PAMELA

31. Date filed (Month, Day, Year)

D0068454

York Rd, Baltimore, MD 21212

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1396 Perma War 91 be bar a left by Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 506 AM Physician/ 2010 Myra Renee Washington Medical 4c. County of Death 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 16-20-1958 1 □ M 2 X F 52 Yrs. 216-78-2533 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State **Funeral Director** 1 X Yes 2 ☐ No Baltimore n/a 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21218 3914 Kimble Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: African-American If Yes, Give 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) State of Maryland-Human Resources Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leona Woolford Melvin Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1613 Ramblewood Road, Baltimore, MD 21239 19a. Informant's Name/Relationship (Type, Print) Rahmaan Rasheed Richardson/Son 20c. Location - City or Town, State 20a. Method of Disposition Date Ring Memoria Almerark 1 X Burial 2 Cremation 3 Removal from State 12/28/2010 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility White Funeral Home F.A. of Balto. Co. uneral Service License 9200 Liberty Road, Randallstown, MD 21133 Part #. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final holangio adenoma 2 months Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year cate has been signed by the page 2 should be detached 9 Linknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Tes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 IDOA မြ 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Watural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 669916795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Sh more MD 21218 Sast Checkley University Meghan ^{Year)} 2010 31. Date filed (Month, Day, State DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40332 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15 20 10 Day Month 12:10A M Physician/ Winstead Patricia Deumber Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Seasons Hospice Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** Days Hours Months 0472071943 North Carolina 1 □ M 2 🖾 F Director 213-40-1929 Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 X No Woodlawn MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States by Funeral 21207 5524 Hutton Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic (Specify only highest grade completed) Convenience Store Elementary/Seconday (0-12) College (1-4 or 5+) Entrepreneur Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mavelyn Creech 2 Wayland Saddler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5524 Hutton Ave Woodlawn MD 21207 19a. Informant's Name/Relationship (Type, Print) Wayne Viens / husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 12/17/2010 Sykesville, Maryland Crestiawn Memorial 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne ature of Funeral Service, 2719 Hammonds Ferry Rd. Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ END. Small resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year						
	contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown						
		24a. Was an autopsy available prior to completion of cause of death? ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes 2 ☐ No						
25. Was case referred to medical	26. Place of Death (Check only of	26. Place of Death (Check only one)						
examiner? 1 Yes 2 No	Hospital:	me 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. D	28d. Describe how injury occurred						
3 Suicide 6 Could no 4 Homicide determine	t be 28e. Place of Injury - At home, farm, street, factory, office 28f. Lo	ocation (Street and Number or Rural Route Number, ity or Town, State)						
(OL I. O Bladical Eve	hysician: To the best of my knowledge, death occured at the time, date and place, and due aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the tiruse Practioner: To the best of my knowledge, death occurred at the time, date and place, and	me, date and place, and due to the cause(s) and mariner stated.						

29c. License number

00057465

29d. Date signed (Month, Day, Year)

12/15/10

5-263 - Baltimore, MD. 21218

State Registrar

Medical

29b. Signature and title of certifier

MS Ry ApamlM·D.

31. Date filed (Month, Day, Year)
DEC 2 1 2010

N.S. Rajapakce MD 32. Registra 's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2535 Smith M-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 17, 2010 Emil G. Wode 2:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ridgeway Manor Nursing Home Catonsville Baltimore 8. Date of Birth (Month, Day, Yea Aug. 11, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** ^{Year)}192<u>6</u> 1 **X** M 2 □ Days 84 213-28-6156 Maryland **Director** Usual Residence of Decedent items 23a or 28a-f show her must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Catonsville Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 5741 Edmondson Ave. Rm. 110 21228 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Whittman Elementary/Seconday (0-12) College (1-4 or 5+) Surveyor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alwin Wode Marie Belloff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Wilton Drive., Halethorpe, MD 21227 Dawn Jacobs/ Niece Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ABurial 2 Cremation 3 Removal from State 12/21/2010 Loudon Park Cemetery Baltimore, MD 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. neral Service Lices 1328 Sulphur Spring Rd., Arbutus, MD 21227 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Consective Physician/ disease or condition resulting in death) ie ural week Medical Due to (or a consequence of): Examiner source morns if any, leading to immediate cause. Enter Underlying Examine attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chronic 24a. Was an autopsy perforn Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 5 Pending 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after or To the Funeral Direct City or Town, State) Medical 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d, Date signed (Month, Day, Year) Delet Wish 17, 2010 29b. Signature and title of certifier 1处754 Getha Leyn WD

State Registrar 31. Date filed (Month, Day, Year)

Baltmare

MD-21227

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GETHA RAZA MD, 4367 HOMMS Febry

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18ªy becember 2010 11:08 AM Raymond L. Wiley, III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🛛 M 2 🗆 F Days Hours Min. 09-24-1939 Director Maryland 71 212-36-9145 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Parkville 1 Yes 2 X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 2721 Alden Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 ☑ Never Married 2 ☐ Married ☐ Yes 2 💢 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 🗆 Widowed 4 🗆 Divorced Specify. White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Sun Paper Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edna M. Tvler Raymond L. Wiley, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles W. Norwalsh - Friend 2721 Alden Road Parkville, Maryland 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corporation 12/20/2010 | Towson, Maryland 22. Name and Address of Facility 21. Signature A Funeral Service Lic 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner Due to jor as a consultience of If any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown alsase 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

32. Resistrar's Signature

lowson

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1:15 PM F. Willner Frederick 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner EL CAM KW If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, June 29 9. Birthplace (State or Foreign **Funeral** Year) 1927 Maryland 1**X** M 2□ F Months Days Hours 216-20-6376 83 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, I'm Mudical Evariated rust be notified at Director 1 ☐ Yes 2X No Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21222 2015 Codd Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∰Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2 □No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainmetr. Elementary/Secondary (0-12) College (1-4or 5+) Trucker's Union Truck Driver 6 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Long Frederick Willner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3100 Glenmore Avenue, Baltimore, Maryland Frederick F. Willner Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery Parkville, Maryland 22, 2010 4 Donation 5 Dother (Specify) 21. Signature of Furthral Service Licensee Conneily Fufferal Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the dise re, shock, or heart failur. List complications that caused the dealy only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burialattending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 ☐ No 3 ☐ Probably 1 🗌 Yes Completed 74b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an page 2 autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🕍 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this o 124 hours after death.

e Funeral Director: After this letely filled in by the funeral. 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

DHMH 17 Rev 1/2001

larne and address of person who completed

31. Date filed (Month, Day, Year)

cause of death often 23a) (Type, Frint)

wark.

32. Registrar's Signature

10-09663	
Patricia Ann	Wilson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 1 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1- For State Regiatrar	•	(Certifica	ate of	Death		75	Reg.	No.	
Physi		1. Decedent's Name (First, Midd				_		_		te of Death		3. Time of Death
Medical Exa	mine	Patricia 4a. Facility Name (if not instituti	A.					lson		cember 1	5, 2010 4c. County of D	1201 hrs
		Meritus Medical Cent					4b. City, Town, or Location of Death Hagerstown			Washington		
Funer	al	5. Social Security Number	6. Sex	7. Age (In	yrs. last birth	nday)	If Under 1 Ye			ate of Birth (MM/DD/YYYY) 9	Birthplace (State or Foreign
Directo	or	159-36-8375	1 M 2 X F		66	Yrs.	Months Da	ys Hours	Min.	04/09/19	944	Country) PA
		Usual Residence of Decedent								,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
ow a o y		10a. State 10b. County			Classes		on					10d. Inside City Limits
Aaryland	ig is	PA Clear	1610		Clearf	rero	10f. Zip Code			1400	0.25	1 X Yes 2 No
e Mar	al Director	2116 Logion Dood					,				Citizen of What	Country?
with th		2116 Legion Road	12. Was Dece	edent Ever	in U.S.	13. Was	16830 Decedent of Hi	spanic Origi	in? (Specify)		S.A.	merican Indian, Black,
leath r item	Funeral	1 Never Married 2 N	Parried Armed For	rces?	No.	If Ye	es, specify Cuba	n, Mexican,	Puerto Rican	, etc.)	White, et	
after	ŭ -		vorced If Yes, Give Yeer				Yes 2X No				Specify:	White
hours	Completed by	15. Decedent's Education (Spe					's Usual Occupa est of working life			one 16	6b. Kind of Busine	ess/Industry
36 in 72	pet	Elementary/Secondary (0-12)	College (1-	4 or 5+)	Owr		.		,		Modical D	illing Co
d with	Completed	17. Father's Name (First, Middle	, Last)		OWI	ICI		18.Mother's	s Name (First.		den Surname)	illing Co.
215 be file ntal H	Be	Joseph	М.		Donahu	<i>i</i> e		Ann	(,		Frank
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 27 is marked other thao					19b	. Mailing	Address (Stre	et and Numl	ber or Rural F	Route Numbe	r, City or Town, S	
MC 2 sl alth ar		Joseph Wilson, So	n		51	5 Her	nderson Ro	oad, Ju				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.		1 Burial 2 Cremation	n 3 X Removal fro		cremato	ry or oth	tion (Name of ce er place)	emetery,	Date		0c. Location - Cit	y or Town, State
ti Pag tment rtaot:		4 Donation 5 Other S			St. Ma		Cemetery		12/20/2		St. Marys,	
Bal Permi Depar		21. Signature of Funeral Service					ame end Addres 05 Harford		700	nard J.	Ruck, Inc	•
Physicia	n	23a. Part I. Enter the disease, o	complications that car	used the d	eath. Do no							Approximate Interval
/Medica		failure. List only one cause Immediate Cause (Final disease	TT - 1 7	Injur	ies							Between Onset and Death
'xamine	11	or condition resulting in death)	Due to (or as a						-			
	70	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	CORROGUER	oce of):							
	i i	cause. Enter Underlying Cause		oonsequer	100 01).							
8	Examiner	events resulting in death) Last	Due to (or as a d	consequen	ice of):							
760, reate be executed physician and the burner of the bur	<u>ड</u>	X UNPENDED	dAMENDED	23a,	27,28	a-f	per me	g911	1-28-1	l vt	<u> </u>	
760, icate be physici	Medical	IF FEMALE:	23c. If yes, or								23d. Date of del	iverv
x 687 h certificatending p	an/l	23b. Was decedent pregnant in t past 12 months?	he 1 Live bir	rth	2	Fet	al death 3	Ectopic	pregnancy		Month	Day Year
Box 687 death certific	Physician	1 Yes 2 V No 9 Un	known 9 Unknow	int at time	of death 5	Oth	er (Specify)				8	
that the d		Part II. Other significant condi			not resulting	in the ur	nderlying cause	given in Par	t I. 2	3e. Did toba	cco use contribute	e to the cause of death?
K 20 30 9												Probably 4 V Unknown
Division of Vital Records, talor Atteodog Physiciso: The law requirers after death. By Director: After this certificate has been is red in by the finered for season of the state of the property.	Completed								2	4a. Was an		e autopsy findings available
eco he law te has	E E								—	autopsy performe ✓ Yes 2	deat	
tal Rections The certificate	Be	25. Was case referred to medica					26.Plac	e of Death (Check only or		140	Yes 2 No
Division of Vital Rections of Attaching Physicians: The cours after death. Peral Divertor: Afficient this certificate filled in by the fanged dispage reasons.	10 8	examiner? 1 ✓ Yes 2 No	Hospital: 1 🖊 In	patient 2	2 ER/ O u	tpatient	3 DOA	Other ₄	Nursing Hom	e 5 Re	sidence 6 0	Ither:
log P	٦	27. Manner of Death 1 Natural 5 Death		f Injury Day,Year)	28b. T	ime of In		ury at Work?		Describe how	injury occurred	
	catic	J Pen	ding stigation fd 12-				nrs. –	Yes 2 X	su	bject		
Divisi ospital or Att hours after de noeral Direct	Certification:	dete	ld not be rmined (Specify)		At home, far		t, factory, office	building, etc				r Rural Route Number, City nbrook Lane
Divis the Hospital or A hin 24 hours after or the Fuoeral Direct the f	5 T	292 Codifier	(0,000.)/				ad at the time of	ate and alac		erstov		21742
Dir To the Hospital of within 24 hours all To the Fuoeral I	Medical		hysician: To the best miner: On the basis of	examinati								
T Wit	₹	29b. Signature and title of certific	and manner sta	41 0 0.			29c. Licens	se number		29	9d. Date signed	(Month, Day, Year)
		1/2	M. Ki	XTP		λ	O.C.	M.E.	OGME		December 16	, 2010
		30. Name and address of person				W.						
		Theodore M. King, Jr.			al Exami	ner	111 Penn St	reet, Balt	timore, MD	21201		
	State strar	115-1 "2 2 2111	32. Reg	istrar's Si	nature	A CONTRACT	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 19, Physician/ 20°10 1:45am M Eleanor Smith Wagner Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore 237 Sacred Heart Lane Reisterstown 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 5-28-1916 Days 1 🗆 M 2 💢 F Hours Min. MD Director 232-01-8383 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a. State notified at Director 1 Yes 2 No Baltimore Reisterstown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Completed by Funeral 23a United States 21136 237 Sacred Heart Lane Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian ral", or item Examiner n Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2**XX**No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 🕅 Widowed 4 🗌 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sebring Ethel Samue1 Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Reisterstown, MD 21136 Glyntree Garth Department of Health Important: If item 27 any injury or other tr Dennis B. Smith Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 12/27/10 Owings Mills, MD Garrison Forest Vet. 4 Donation 5 Other (Specify) 22. Name and Address of Facility ELINE FUNERAL HOME Signature of Funeral Service Licensee 11824 Reisterstown Rd. Reisterstown, MD 21136 23a. Part 1. Errier the size se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ morary Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ed by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be det Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 NA ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending after death. 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined filled in 24 hours a Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier

State Registrar M

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mai	ryland /		irtment of F tificate of D				giene Reg. No.	2016	1 1.0338)
П	Physicia	n/	1. Decedent's Name (First, Middle, Las	,						2. Date of De	ath	Year	3. Time of Death	-
	Physicia Medic	al	Evelyn Wa 4a. Facility Name (If not institution, give	ranch number		T	41- O't- T		(В	Decemb			7:30 PM	
	Examin	er	NORTH OAKS HEAL!				4b. City, Town, or BALTIM		n of Death			County of Dea		
	Funeral		Social Security Number 6. S		In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days		ler 24 Hrs. Min.	8. Date of Bird (Month Da 08/19/	th	9. Bir	rthplace (State or Foreign	
	Director ≥		Usual Residence of Decedent	Λ	92	113.				06/19/	1910		MD	_
	ryland I-f sho ied at	ctor	10a. State 10b. County		I0c. City, To								10d. Inside City Limits	
	he Ma or 28a e notif	Dire	MD BALTII 10e. Street and Number	MORE	BAL	TIMOF	10f. Zip Code				10g. Citiz	en of What C	1 Ves 2 No	_
	s 23a nust be	Funeral Director	725 MT. WILSON	LANE			21208	3			Ü	USA		
36	e filed within 72 hours after death with the Maryland ttal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give		If	/as Decedent of Hi Yes, specify Cuba	n, Mexic	an, Puerto I	cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit	te, etc.	
0	hours a	letec	3 Widowed 4 Divorced 15. Decedent's E	Year or Dates. ducation	16		ent's Usual Occupa					d of Business	WHITE	
1215	nin 72 ne. than "r e Med	Completed	(Specify only highest gra Elementary/Seconday (0-12)	ade completed) College (1-4 or 5+)	77	life. DC	ind of work done d NOT use retired)	luri n g me	ost of worki	ng	1			
d 2.	led witl Hygier other t ent, th	BeC	12 17. Father's Name (First, Middle, Last)			HOME	EMAKER	18. Mo	ther's Name	(First, Middle,		N HOME	<u> </u>	_
/lan	should be file n and Mental H 7 is marked o raumatic eve	입	LOUIS	SCH	LOSSB	ERG_			DA	, ,			LVERMAN	
Maryland 21215-0036	shoul h and 7 is m trauma		19a. Informant's Name/Relationship (T)		11	,	g Address (Street a						ip Code)	
ē,	1 and 2 should be of Health and Mentre item 27 is marked other tranmatic ether tranmatic		LESLIE GUTMAN/DA 20a. Method of Disposition			of Dispos	SIVY LAN			oate		ation - City or	r Town, State	_
Baltımore,			1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil				atory or other place IEMORIAL		12/19	9/2010	RA	NDALLS	STOWN, MD	
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	Cittle			Name and Addres						=	100
	nysician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.			,	g, such a	as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death	01
mar of	Medical Examiner		disease or condition resulting in death)	a. Letto or as a control of the cont	consequen	e of):	lar Di	\$-P(1)						11
	n #	niner	Sequentially list conditions, b. Due to (or as a consequence of): cause. Enter Underlying											
	rate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a c	consequence	insequence of):								
Q	ate be o	edical		d										_
. Box 68/		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	☐ Fetal dea		Ectopic pregnanc Other (specify)	у			23	3d. Date of de Month	elivery Day Year	
s, P.O.	ires that th signed by Id be deta	þ	Part II. Other significant conditions of Coronary Arter	ontributing to death but	not resulting	g in the un	nderlying cause giv	en in Pa	ırt I.				o the cause of death?	
Division of Vital Records,	ne law requ e has beer age 2 shou	Completed	\	\						24a. Was autor perfo	osy rmed?	prior to death?	utopsy findings available completion of cause of	
<u>e</u>	sian; Ti ertificat ctor, pa		25. Was case referred to medical examiner?	W = 73					eath (Check	1 \(\superstack \text{Yes}\)	2 LT No	1 □ Ye	s 2 🗆 No	
<u> </u>	Physic this or	욘	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of injury	_	Outpatient	Othe	4 🗷		me 5 Resid			cify)	_
o uc	inding ath. r: After ie fune	icate	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, \		injury	work'	? Yes 2	_	ou. Describe n	low injury t	ccurred		
JVISI	al or Atte s after de il Directo ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc. (farm, stree	et, factory, office			28f. Location (S City or Tow		Vumber or Ru	ural Route Number,	
	he Hospit in 24 hour he Funera pleted filk	Medical	(Check 2 Medical Exami	sician: To the best of my ner: On the basis of exar se Practioner: To the be	mination and	d/or investig	gation, in my opinio	n, death	occurred at	the time, date a	nd place, a	nd due to the	cause(s) and manner states	ed.
	To t with To t		29b. Signature and title of certifier	che			29c. License			_	-	signed (Mont	th, Day, Year)	
			30. Name and address of person who of Dorothy Secy	completed cause of deal	th (Item 23a	(Type, Pr								
	Stat Registra		31. Date filed (Month, Day, Year) DEC 2 1 2010	32. Registrer's	Sign	Kal								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / U State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pok Song Υi December 2010 2:43 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 6. Sex 8. Date of Birth (Month, Day, Year) Jan 15, 1930 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2X F **Director** 511-74-7118 Yrs. 80 Korea Usual Residence of Decedent show ld be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 135 Elmira Lane 20878 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Yes Yes, Give 2 XNo Baltimore, Maryland 21215-0036 Specify: Asian 1 Yes 2 No Specify: 3

Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Jisick Cho Ung Soon Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. In Sun Yi/daughter 135 Elmira Lane Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/20/2010 Woodbine, Maryland 21. Sign of Funeral Service License Going Home Cremation Service P.O. Box 784 uanita M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Colon Cancer with Metastasis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy in the past 12 months? Hospital or Attending Physician: The law requires that the death Day Year 5 Other (specify) Pregnant at time of death 2**X** No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 🔲 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 XOther (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined in 24 hou. The Funeral D 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number D0060634 December 18, 2010 30. Name and address of peleon who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, M.D. 6001 Muncaster Mill Road Rockville, Maryland 20855 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ZUCKER Physician/ DECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northwest Baltimore Hospital Randallstrun Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min Director Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 6702 Chishdm USA Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 ₩ Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) tccountaint Public Ά is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. Sam Zucker Anna Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Bush Lane Clarks ville MD /Gvandlaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 22 2010 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Druid Kidge Cometery ! 21. Signature of Funeral Service Licensee Greene Fureral services Vaugin L Road Pandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death HEART FAILURE Physician ONGESTIVE Medical Due to (or as a consequence of) Examiner DISEASE OA DAAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown 4 ☐ Pregnam 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MITRAL REGULANTATION 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION ULMONARY SEVERE . Were autopsy findings available prior to completion of cause of death? this certificate has autopsy PLEURALEFFUSION NAL FAILURE performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director, æ 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No မ 1 N Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accide 5 \square Pending 2 Accident
3 Sulcide
4 Homicide 1 Tes 2 No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statted. certifier 29b. Signature and 29d. Date signed (Month, Day, Year) DECEMBER 19 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOTH WEST AVVERA HALLI M FINALSH NORTH WEST HOSPITAL CENTER

Registrar DHMH 17 Rev 7/2009

State

'ERAHALLI

Date filed (Month, Day, Year)

DEC 21 2010

32. Registrar's Signature

RANDALLSTOWN

MD 2(133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBE Year 2010 04-05AM 10 onte Medical 4a. Facility Name (if not institution) give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT MEMORIAL HOSPITAL EASTON AT EASTON If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖼 F 05 Months Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Easton 1 Yes 2 No albo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Kound House (21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 □ No Specify: Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Heusewife To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julio ponte Tarcola 19a. Informant's Name (Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Round House isette Vazquez ircle Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date of other place) 1 Burial 2 Cremation 3 Removal from State 12/14/2010 izabeth, N.J. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 10455 Southern Blvd Bronx KG. Orliz F.H. 524 23a. Part 1. Ent y the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARCINOMA CHOLANGIO METASTATIC MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to or as a consequence of use as the burial-transit been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last The law requires that the death certificate be IE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Vear ☐ Pregnant at time of death☐ Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 and autopsy performed death? 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 🗓 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 DO0 66441 tranch DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTON RAMESH 2195 MOTERNIA 2AGO MD 21601 KOLLI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar > DHMH 17 Rev 7/2009

210

 \leftarrow

大人子

APPNIE,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 13, Physician/ ^{Day}2010^{Year} William 1648 Dennis Aanew Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany 5. Social Security Number Birthplace (State or Foreign Country)

WV If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth Min 1 XM 2 1 F Months Hours May 16 Director 235-<u>70-3224</u> Yrs. 65 Usual Residence of Decedent or 28a-f shov 10a. State Director 10c. City, Town or Location be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits WV Burlington Mineral 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Rt. 1 Box 170 26710 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Coal Equipment Operator Power Plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Ruth (Rotruck) Agnew William Agnew permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code **Dorothy Agnew** wife Rt. 1 Box 170 WV 26710 Burlington 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ **%**remation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 12/14/2010 MD Cresaptown 4 Donation 5 Qther (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA Signatur of Funeral Arvice Licensee 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death,

To the Funeral Director: After this certificate 2 No _ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 □ Certifying Nurse Practi oner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Amm m.D

2

Registrar's Signature

Knew

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/29/2010 Physician/ Lillie Ruth Boone 11:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Sykesville Brinton Woods Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F Months Hours Min. Month Pay, 18917 **Director** 213-03-4203 93 MD Usual Residence of Decedent 28a-f show 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2208 Sharidan Dr. 21157 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Her Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Boblitz Birdie Barger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) œ. and 2 s Health tem 27 2208 Sharidan Dr., Westminster, MD 21157 Barbara Fogler/Daughter permit. Page 1 and . Department of Healt Important: If item 2 any injury or other a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State Donation 5 - Other (Specify) 12/3/2010 Pikesville, MD Oruid Ridge Cemetery 21. Sig e of Funeral Service Licens 28 NTT Tel Add Cold En lin Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 rt 1. Enter the disease, or complication ock, or heart failure. List only one cause o used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, that Immed the Cause (Final disease or condition resulting in \$1.00) Onset and Death EGENERATIVE Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to or as a consequence of: cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 1 No 2 - No Yes in 24 hours after death.

he Funeral Director: After this certific pleted filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 400 Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 \(\text{Yes} 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 20806 ull sun 2010 30. Name and address of person whe completed cause of death (Item 23a) (Type, Print) 21136

Registrar DHMH 17 Rev 7/2009 VAIRICK

31. Date filed (Month, Day, Year,

Box 68760

P.0.

Division of Vital Records,

BUSIARS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOSEPHINE V. BOZOUKOFF DECEMBER 2010 8:40 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death CORSICA HILLS NURSING HOME CENTREVILLE OUEEN ANNE'S If Linder 1 Year | If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days 1 M 2 XF Months Hours Min NOV. 26, PENNSYLVANIA Director 95 181-38-4720 Usual Residence of Decedent or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Tes 2 XNo QUEEN ANNE'S CHESTER MARYLAND 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 2601 COX NECK ROAD 21619 UNITED STATES 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 REGISTERED NURSE 1 HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည be f LOUIS D. TURACK YENKA SPINCIC Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNE GERG/ DAUGHTER 2601 COX NECK ROAD, CHESTER, MARYLAND, Baltimore, 20a. Method of Disposition MONROEV FLYCE own, State 20b. Place of Disposition (Name of RES-Elf-AND) mREMORI (Alge) DECEMBER 9. nent of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important: If any injury or PENNSYLVANIA **PARK** 2010 Sign Mr funeral Service Licensee fellows, helfenbein & Newnam Funeral Home, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 21619 luc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cho353 or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? After this certificate 1 Yes 2 No funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 27. Manner of Death 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural (Month, Day, 5 Pending work' 1 Yes 2 No Accident Investigation in by the within 24 hours after deal To the Funeral Director: Suicide 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, it into opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MS 30. Name and address of person who completed cause of ath (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day

Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#8 per FH State of Maryland State Registrar 12/7/2010 AACO HEALIH DEPT CMH Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 01:54 AM Edward Beckman Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's <u>Laurel Regional Hospital</u> Laurel 8. Date of Birth 178/48 (Month, Day, Year) 6. Sex If Under 1 g. Birthplace (State or Foreign County) Maryland Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** 1 M 2 □ F Months Days Hours Min Yrs Director 62 215-50-3517 ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Laurel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20707 7807 Brooklyn Bridge Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 er than "natural", (; the Medical Exan 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72.1 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Communication Comp. Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Merta
Important: If item 27 is marked, any injury or other trees, once ၉ Albert T. Beckman Betty Benson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Beckman - Wife 7807 Brooklyn Bridge Road, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Elkridge, Maryland Meadowridge Mem. Park 12/02/10 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 Funeral Service Lice 21. Signature of M01283 23a. Part Enter the di least, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lut only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dus to for as a consequence of Exami death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-1 Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No signed by the a d be detached f 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an autopsy certificate ha death? 1 ☐ Yes 2 ☐ No Yes 2 V No To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifies completed filled in by the funeral director, t Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🟋 No Other: 1 _ inpatient 2 ER/Outpatient 3 _ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place only one) and due to the cause(s) and manner as stated 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willner, M.D. 7300 Van Dusen Road Laurel, MD 20707

Registrar
DHMH 17 Rev 7/2009

State

Henry \
31. Date filed (Mor

Registrar's Signature

6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2, 2010 1:58 Dolores Elaine Baxter AΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Grasonsville Oueen Anne Heartland House If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Days July 21, Hours Towa 1923 Director 577-24-5886 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No Stevensville <u> Maryland| Queen Anne</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21666 112 Allegany Avenue 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Human Resource Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Ruby Woodfin Floyd Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2711 Felter Lane Bowie, MD 20715 Ken Louis Baxter/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBunal 2 Cremation 3 Removal from State cemetery crematory or other place; Sacred Heart Church Cemetery 4 Donation 5 Other (Specify) 12/6/2010 Bowie, MD 21. Signature of Funeral S. Vice 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 1 Yes 2 Unknown signed by the a 9 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate ha completed filled in by the funeral director, page. 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 🗆 Yes 2 🗆 No Investigation 6 Could not be ☐ Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie h.D D23867 12-2

death (Item 23a) (Type, Print)

Sallit Drive Stevensuille; MD 21666 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)
DEC 0 6 2010

Box 68760

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 7:10 AM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13308 Yorktown Drive Prince Georges Bowie 9. Birthplace (State or Foreign Country)
France Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🛣 F Days Min. (Month, Day, Year **Director** 216-48-8557 87 Dec Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince Georges Greenbelt Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20770 USA 7852 Somerset Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married δ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Karl Mertz Caroline Erb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7852 Somerset Court Greenbelt, MD 20770 Daniel P. Byrd/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, prematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Washington Crematory 12/4/2010 4 Donation 5 Other (Specify) Laurel, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service License 16000 Annapolis Road Bowie, MD 20715 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Malignant Cardiac Arrhythmia Medical resulting in death) **Examiner** Coronary Artery Disease Sequentially list conditions, Examine Due to for as a consequence of, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available nas prior to completion of cause of death? 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ XOther (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural work? injury 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Box 68760 P.0. Records, Division of Vital Hospital or Attending n 24 hours after death.

e Funeral Director; Aft соmpleted

DHMH 17 Rev 7/2009

20

Registrar

State

29a. Certifier

only one) 29b. Signature and Me of certifi

31. Date filed (Month, Day, Year)

DEC 0 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Rexford A. Babilah, M.D. 7500 Hanover Parkway Suite 101A Greenbelt, MD 20770

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

11/30/2010

29c. License number D66658

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 WILLIAM MONROE BOND A^{M} DECEMBER 2010 8:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARFORD HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 □ F 64 10/09/1946 MARYLAND 218-46-2008 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 17√2 Yes 2 🗌 No MARYLAND HARFORD BELCAMP 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4315 DECLARATION CIRCLE 21017 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1965–69 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify. Specify: BLACK 3 ☐ Widowed 4 🎇 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EXPLOSIVE TEST OPERATOR ARMY TEST CENTER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GOVER DANIEL BOND PAULINE ELIZABETH JASPER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA L. WILLIAMS / FRIEND 1442 OLD STEPNEY ROAD, ABERDEEN, MARYLAND 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/10/10 BERKLEY CEMETERY DARLINGTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence f): Sequentially list conditions, Due to (or as a consequence of) trany leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 🗖 No 26. Place of Death (Check only one) 1 Yes 2 No

Examiner be execute and burial-tran attending physician for use as the burial the signed by t page 2 should has certificate

After this

Records.

of Vital

Division

Physician

/Medical

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

ပ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examiner must be notified at once.

Maryland 21215-0036

Physician/Medical þ Completed æ To the n.c., within 24 hours after c.c.
To the Funeral Director: After c.c. Certification: To

25. Was case referred to medical examiner?

27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation 6 □ Could not be 3 Suicide 4 Homicide

29b. Signature and title of certifier

29a, Certifier

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

038933

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

200d Sork 102 Bel Air, Maryland 21015 Knight MD 104 Plustree

and manner stated.

State Registrar

Medical

32. Registrar's Signature 31. Date filed (Month, Day, Year,

5+IVA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3: 20 A Physician/ Month Dec Day 08 Year 1 C Anna Ruth Brown Medical 4a. Facility Name (if not institution, give street and number)

Elkton Care & Rehabilition Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil Elkton, MDSocial Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X X** Months Hours **Director** 214-12-9731 1918 92 Grayson, Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified 28a-f Cecil E1kton 1 Yes 2XXIo with the 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Completed by Funeral 21921 USA 1 Price Drive items and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Examiner Black, White, etc. ō 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal If Yes, Give Specify: 3 XWidowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b, Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurses Aide Perry Point V.A. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nancy Elizabeth Carr Houston Samuel Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 165 Augustine Herman Hwy, Elkton, MD 21921 Barbara Snyder, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date . Page 1 1 Burial 2 X Cremation 3 Removal from State R.T.Foard Funeral Home 12/9/ O Rising Sun, MD 4 Donation 5 Other (Specify) eral Service Licensee Signature of Fu 22. Name and Address of Facility R.T. Foard Funeral Street, Rising Sun, Oueen 23a. Part 1. Inter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. ot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Pregnant at time of death Month Dav Year Pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe Yes 2 X ☐ Yes 2 No funeral director, 25. Was case referred to medical B B 26. Place of Death (Check only one, 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Exactioner: To the best of my ancient of the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed (Check To the within 2 To the F only on 29b. Signature as 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) Name and address of person who completed cause of death 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 10 12 04 Cecile Boesche 11:10 AM Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Health Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 4/23/1920 213-14-5480 90 **Director** Virginia Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Director Kingsville MD Baltimore 1 Yes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21087 11106 Towood Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Medical Nurse 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked or 0 William Preston McDaniel Georgia Hudson 19a. Informant's Name/Relationship (Type, Print)
Lee Ann Petty – Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11106 Towood Road, Kingsville, MD 21087 Department of Health a Important: If item 27 is any injury or other tran 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3.☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Orlando Crematory 12/06/2010 Orlando, FL 22. Name and Address of Facility C&A Removal Services 21. Signature K W R MO1080 180 Sister Chipmunk Ln. Clear Brook 22624 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Yea 5 Other (specify) Pregnant at time of death Pregnanτ : Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has death? 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Maryland 21215-0036

C3H-2 State

Registrar

29a, Certifier only one)

29b. Signature and title of gertifier

led (Month, Day, Year)

DEC 0 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

gistrar's Signature

29c, License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day WILLIAM T. BROWN 1:03F M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death .**≸**ex 1 **X** M 2 □ F 7. Age (In yrs. last birthday If Under 1 Year 8. Date of Birth Funeral 9. Birthplace (State or Foreign 230-32-7201 (Month, Day, Year) -30-1931 VIRGINIA Director 79 Usual Residence of Decedent shov 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 28a-f **DELAWARE** SUSSEX **GUMBORO** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be or items 23a Funeral 38635 MILLSBORO HIGHWAY 19966 UNITED STATES death 12. Was Decedent Ever in U.S. "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Willid Maryland 21215-0036 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 51-54 1 ☐ Yes 2 🔀 No Specify: WHITE 3 🔀 Widowed 4 🗆 Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygien Important; If item 27 is marked any injury or **** ELECTRONICS ENGINEER NYLON PLANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ T. LEWIS BROWN MAUDE E. TULLOCH 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH C. COLLINS / DAUGHTER 38635 MILLSBORO HWY, MILLSBORO, DE. 19966 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State MELSONS CREMATORY 12-10-10 FRANKFORD, DELAWARE 4 Denation 5 Other (Spegify) 21. Signature of Funeral 22. Name and Address of Facility
MELSON FUNERAL
43 THATCHER ST. SERVICES, FRANKFORD 23a. Part 1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. As to only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MALIGNANT CARCONOWA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Facus nticily list nonclions if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Tes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy perform 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manger of eath 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending (Month, Day, Year) death. 2 Accident 1 Yes 2 No s after death Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D 29a. Certifie ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nursi. Practioner: To the state of the state of the cause(s) and manner stated cortifying Nursi. Practioner: To the state of the state of the cause(s) and manner stated cortifying Nursi. Practioner: To the state of the cause(s) and manner stated cortifying Nursi. Practioner: To the state of the cause(s) and manner stated cortifying Nursi. Practioner: To the state of the cause(s) and manner stated cortifying Nursi. Practioner: To the state of the cause(s) and manner stated cortifying Nursi. Practioner: To the state of the cause(s) and manner stated cortifying Nursi. Practioner: To the state of the cause(s) and manner stated cortifying Nursi. Practioner: To the state of the cause(s) and manner stated cortifying Nursi. Practioner: To the state of the state of the state of the cause of the state of the sta (Check only one 29b. Signature and litle of certifier

BA 10+1

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 5-2 Year Gerald Joseph Burch Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Sallsbury Hospice a t Nicom If Under 1 Year If Under 2 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🖾 M 2 🗆 F Months Hours Min. Country) 3/19/11935 291-28-3231 75 OH Director Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits with the Maryland Director 10c City Town or Location the Medical Examiner must be notified at 1 Yes 2 X No MD Berlin Worcester 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 21811 USA 64 Whitehorse Dr. be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0036 Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other tha any injury or other traumatic event, the It once. Chemical Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Raymond Burch Kathryn Tvorach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madonna Burch/Wife 21811 White Horse Dr., Berlin, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 24 Cremation 3 Removal from State cemetery, crematory or other place) 12/10/10 1st State Crem. Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 Berlin, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ LUNG CARCINOU MALICINAN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes Yes /2 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 2 PNo Other: 4 Nursing Home 5 Residence 1 Inpatient 2 I ER/Outpatient 3 I DOA 24 hours after death.
Funeral Director: After this leted filled in by the funeral directed directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Natural 5 Pending work 1 Tes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie DO05 2400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1401 MC4 State

DHMH 17 Rev 7/2009

Registrar

6 Huston 31. Date filed (Month, Day, Year)

32. Registrar's Signature

33

Strisburg unp

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death rooks Physician/ Devese Susan Month Cember Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death County Howare General Olumbi 5. Social Security Numbe If Under Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 218-46-1932 1 - M 2 X F Min 63 02/06/1947 **Director** MD Usual Residence of Decedent or 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Howard Laurel 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10507 Graeloch Road 20723 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 ☐ Never Married 2 🏻 Married Yes 2 No White If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify Specify: Completed 3
Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John DeVese Lucy Adams Lepartment of Health and Important: If item 27 is many injury or other ones. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derward A. Brooks - husband 10507 Graeloch Road Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State John's Cemetery 12/10/2010 4 Donation 5 Other (Specify) St. Ellicott City, MD 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 4112 Old Columbia Pike Ellicott City, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine death certificate be executed alle attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? ᅌ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy perform death? this certificate 2 No Yes 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certificieted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes Other: ဂ္ 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 🗆 No Investigation Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сотретер (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death, (Item 23a), (Type, Print) 12 31. Date filed (Month, Day, Year, . Registrar's Signature

State

Registrar

DEC 08

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

research.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are	Legible.	
State of Maryland / Department of Health and Mental Hygiene	2010	+035
Certificate of Death	Reg. No.	

		I- For State Registrar		Certificate of Death					Re		3 "3	
Physicia Physicia Examir	n/	Decedent's Name (First, Middle Michael	_{e,Last)} Lee	ee Basore				M	ate of Deatl Nonth ecember	3. Time of Death 0246 hrs		
		4a. Facility Name (if not institution 7033 Ed Sears Road		umber)			City, Town, or Location of Death			4c. County of		\neg
Funeral Director		5. Social Security Number 219-44-3759	6. Sex	7. Age (In yrs. I: 64	ast birthday)		ear If Under	er 24Hrs. B. i	Date of Birth	h(MM/DD/YYYY) 2, 1946	9. Birthplace (State or Foreign Mary Land Country)	1
5-0036 ed within 72 hours after death with lygiene. other than "natural", or items 23.	To Be Completed by Funeral Dire	10e. Street and Number 12905 Little 11. Marital Status 1 Never Married 2 Ma	12. Was Dec Armed F 1 Yes or Cod If Yes, GIVA Yes or Dates: ify only highest gra College (* 3 Last) L. ip (Type, Print) tin, Fian Removal fr ecity:	Road cedent Ever in U. orces? 2 X No ar de completed) 1-4 or 5+) Basore ce/Exec om State Smi	16a. Deceder during m 19b. Mailin 12905 Place of Disportermatory or ot the burn 22. N	as Decedent of It / Yes , specify Cub Yes 2X Notes Usual Occupost of working It Analyst G Address (Structure of Cher place) g Crema Yeme and Address (Structure of Cher place)	an, Mexican lo specify: ation (Give life, DO NOT life, DO	kind of work cuse retired) 's Name (First Idine ber or Rural I etam R Date 17	ryes or No- n, etc.) done Route Numi Rd, Ha te 7,2010	White, Specify: 16b. Kind of Bus DMA/Fec laiden Surname) Kerr ber, City or Town gerstown 20c. Location - C Smiths Ineral H	American Indian, Black, etc. White Iness/Industry Goverment State, Zip Code) MD 21742 City or Town, State burg, Maryla Ome	no
Physician /Medical 	Examiner	23a. Part I. Enter he disease, or failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate eaus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Atheroscle Due to (or as a b. Due to (or as a	aused the death.	Do not enter t ascular Dis	he mode of dyin	GNUTCI g, such as c	1 St f	ETEGE1	st, shock, or hear	ryland 21701 t Approximate Inten Between Onset ar Death	rval
Box 6876 e death certificate the attending phy ed for use as the	hysician/l	UNPENDED IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk Part II. Other significant condition	1 Live b 4 Pregr nown 9 Unknown	ant at time of de	2 Fe	ther (Specify)	Ectopic		23a Did tol	23d. Date of d	elivery Day Year ute to the cause of death?	
Vital Records, P.O. yaicina: The law requires that the law requires that the his certificate has been signed by director, page 2 should be detach	Completed by	25. Was case referred to medical	Contributing to	o dealin but not re	suting III (le t				1 Yes 24a. Was a autops perforr 1 Yes 2	2 No 3 24b. W	Probably 4 Vnknown ere autopsy findings availat or to completion of cause of ath?	vn able of
Division of Vital pptal or Attending Physician ours after death. reral Director: After this cert filled in by the funeral director	ğ	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could	2Ba. Date (Month tigation 28e. Place		ER/Outpatient 28b. Time of I	3 DOA	Other ₄ ury at Work	Nursing Hon 28d. No 28f. I	me 5 F			Sity
Di To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 Certifying Ph	ysician: To the besinner: On the basis and manners	of examination ar		tion, in my opinio		ice, and due t	to the cause	e(s) and manner a		
		30. Name and address of person Melissa Brassell, MD	ssell. N				.M.E.	e, MD 2120	01	December 1		
Sta	-	31. Date filed (Month, Day, Year)		egistrar's Signatu		0						\dashv
Registr DHMH 17 Rev 1/200		OOME	۹.		ORIGINA	L				₹		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year HARRIETT C. 15, 6:00 a BURRIS DECEMBER 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Chestertown Nursing & Rehab Chestertown Kent If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, June 6, Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 6. Sex 1 □ M 2 🔀 F 1920 Maryland

10f. Zip Code

1 ☐ Yes 2 🔀 No

21661

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Elementary School Teacher

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

10d. Inside City Limits

10g. Citizen of What Country?

14. Race - American Indian,

White

Black, White, etc.

U.S.A.

Specify:

Education

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Usilton

16b. Kind of Business/Industry

1 Yes 2 □ No

90

12. Was Decedent Ever in U.S.

1 ∐Yes 2 XNo If Yes, Give Year or Dates:

College (1-4or 5+)

10c. City, Town or Location

Rock Hall

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar research and once.

1 - State Registrar

10a. State

MD

11. Marital Status

Director

Funeral

þ

Completed

Be

ည

222-24-7016

10e. Street and Number

Usual Residence of Decedent

1 ☐ Never Married 2 ☐ Married

3 Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Charles P. Coleman

10b. County

Kent

5750 South Hawthorne Ave.

15. Decedent's Education (Specify only highest grade completed)

Physician

Examiner

Funeral

Director

/Medical

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Be Completed by Physician/Medical Medical Certification: To

Division of Vital Records, P.O. Box 68760,

19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Mariam C. Elbourn (s.	ister) 5750 Sc	outh Hawthorne Ave.	Rock Hall, MD	21661					
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition cemetery, crematory	(Name of or other place) Cemetery 12/18/10	20c. Location - City or	Town, State					
21. Sign Furier Servic, Li ensee	Fari	e and Address of Facility es Funeral Directo South Main Smyrna,	ors & Crematori DE, 19977	um					
23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cay e (Final disease or condition resulting in death)	at caused the death. Do not enter the	mode of dying, such as cardiac or respi	ratory arrest,	Approximate Interval Between Onset and Death					
Sequentially list conditions, if the cause conserving that industry that initiated events c.	A) when we do not a second property	Sease		5 yrs.					
d	to (or as a consequence of):								
in the past 12 months?		oic pregnancy r (specify)	23d. Date of de Month	livery Day Year					
Part II. Other significant conditions contributing to	o death but not resulting in the underlying	3	e. Did tobacco use contribute to	o the cause of death?					
	•		a. Was an autopsy performed? Yes 2 No 1 Yes						
25. Was case referred to medical examiner?		26. Place of Death (Chec							
	☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home 5	☐ Residence 6 ☐ Other (Spe	ecify)					
Natural 5 Pending (M	ate of Injury fonth, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	escribe how injury occurred						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Pla	ace of Injury - At home, farm, street, fac illding, etc. (Specify)	ctory, office 28f. Loc Cit	cation (Street and Number or Re y or Town, State)	ural Route Number,					
(Check only 2 Medical Examiner: On the	the best of my knowledge, death occu e basis of examination and/or investiga anner stated.	rred at the time, date and place, and du ation, in my opinion, death occurred at th	e to the cause(s) and manner a ne time, date and place, and due	s stated. e to the cause(s)					
29b. Signature and title of cartifier		29c. License number	29d. Date signed (Mont	th, Day, Year)					
	CM	30051735	12/15)	10					
30. Name and address of person who completed co	ause of death (Item 23a) (Type, Print)								
Frederick Delboy, M.D.	6602 Church Hil	l Rd. Chestertown	MD. 21620						

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

falls

Please Type or Print in Black Indelible Lak Ensure AlloCapies Are Legible.

Amend 23a Pt II per med Cert Gylocapies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death ^D2010 Physician/ Month 21:45 Edward Cary Bean, Sr. 11 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F Months SEBUT. 1921 417-16-3164 89 A Pabama **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Silver Spring 1 🗌 Yes 2 🕅 No Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 20904 3114 Gracefield Road, WC113 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 \(\text{No} \) Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Year or Dates.1943**–**1946 Completed marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Mechanical Engineer U.S. Government Be permit. Page 1 and 2 should be filed very Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie Mae Carey George Bean Richburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris M. Bean -wife 3114 Gracefield Road, WC113 Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/16/2010 4 Donation 5 Other (Specify) Opp City Cemetery Opp, Alabama 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, PA Signature of Funeral Service License 400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Septic Shock Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Fecal Peritonitis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Cause (Disease or iinjury for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the hirial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant Month Day Year Pregnant at time of death 1 Yes 2 g 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pleural Effusion; CAD; CABG; Parkinson's Disease; 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Respiratory Failure H10 4 Vessel Coronary Artery 24a. Was an autopsy Bypass Graft After this certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

Barbara

31. Date filed (Month, Day, Year)

paruch

Registrar's Signature

Creun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Supanich, RSM, MD HCH 1500 Forest Glen Road Silver Spring, Maryland 20910

D 0065 485

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:05 AM ROBERT ALONZO CHRISTY, SR combe 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Numbe If Unde 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🕅 M 2 🗆 F Months Davs Hours Min. APRIL 20, 1934 Country) MARYLAND 76 Director 216-30-8871 Usual Residence of Decedent show 10a, State 10b. County with the Maryland ural", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND 1 TyrYes 2 No HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 MARKET STREET 21078 UNITED STATES within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify Specify: BLACK "natural", Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) AUTO DEALER PARTS MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WALTER ALONZO CHRISTY SARAH ELIZABETH GILES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT A. CHRISTY, JR / SON 1007 LAKEFRONT DRIVE, EDGEWOOD, MARYLAND 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State R.A. FERRIS & CO. 4 Donation 5 Other (Specify) 12/9/10 WEST CHESTER, PA . Signature of Funeral Service Licenses 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on cook line. 21078 DE GRACE, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ emunta disease or condition resulting in death) Medical Du it (or as a consequence of) Examiner 739 estensi2 Sequentially list conditions, if any, leading to immediate Examine ras a consequence of) burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a cons quence of): attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregna Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes ᅆ Sursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA the funeral 27 Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work? Natural 5 Pending death. 2 🗆 No within 24 hours after death

To the Funeral Director: A

completed filled in by the fi 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signa Month, Day, Year) person who completed cause of death (Item 28a) (Type, Print)

Registrar

State

31. Date filed //Mo

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month 3 155 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Maryland of Medical Baltimere Univ BALTIMORE CITY 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 1**x** M 2 □ F JANUARY 29 217-44-6371 62 MARYLAND Director 1948 Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No NEWBURG MARYLAND CHARLES 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10495 MT. VICTORIA ROAD / P.O. BOX 12 20664 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: BLACK 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working 12TH GRADE life. DO NOT use retired) College (1-4 or 5+) EXPLOSIVE WORKER FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM L. SMALLWOOD LAURA FLORENCE SMALLWOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY Y. CHASE / WIFE P.O. BOX 12, NEWBURG, MARYLAND 20664 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State BRINSFIELD-ECHOLS CREMATORY DEC. 11,2010 CHARLOTTE HALL, MARYLAND 4 Donation 5 Other (Specify) ure of Fune at icensee THORNTON FUNERAL HOME, P.A. LIDIA C. THORNTON JOHNSON M00583 LIVINGSTON ROAD. INDIAN HEAD. MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to las a consequence Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b, Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2. No 3 Probably 4 Unknown Completed 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 욘 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined within 24 hours a To the Funeral I Medical vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c, License numbe 29d. Date signed (Month, Day, Year)

ZB6

Régistrar
DHMH 17 Rev 7/2009

31. Date filed (Month

GIRERR

22

Registrar's Signature

recent

201

30. Name and address of persop who completed cause of death (Item 23a) (Type, Print)

8 2010

DHMH 17 Rev 1/2001

Registrar

DEC 0

Darks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			- State Amend Item 1 per	dr.,g910),12 <u>72</u>	1/2010dbl rtificate of L	Death	rivioritarriy	Reg. N		13 3 pm ps
	Division		1. Decedent's Name (First, Middle, Last)					2. Date of De		4010	3. Time of Death
	Physicia Medio		Jeanne Com	ther	Jea	anne B. C	ompher	Month	06	ay 20 Year	10:25 P M
	Examin	er	4a. Facility Name (if not institution, give street and null UNIVERTITY OF MAMIGNE MED	Location of Dea	ath	4	c. County of Deatl				
- Parker	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year	If Under 24 H	rs. 8. Date of Bi	rth	Baltimo 9. Birt	re hplace (State or Foreign
	Director		171-30-5527 1 □ M 2X F	72	Yrs.	Months Days	Hours Mi		av. Year)	Cor	_{intry)} ynesboro, PA
	now at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ecation					10d. Inside City Limits
	larylar 3a-fsl ified	Director	PA Franklin	1 '	aynesb						YX Yes 2 □ No
	the N		10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	untry?
	n with	Funeral	19 N. Grant St.			17268			US		
	r item		11. Marital Status 12. Was Deco	edent Ever in U.S rces? 2 X No		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (ın, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		14. Race - Amer Black, White	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 ☐ Xilliangle X	re		1 ☐ Yes 2 🔀 No	Specify:				white
2 Q	hour 'natur	olete	15. Decedent's Education (Specify only highest grade completed	- 1		dent's Usual Occup		orkina	16b.	Kind of Business I	Industry
121	thin 72 sne. than than ne Me	Completed	Elementary/Seconday (0-12) College (1		life. D	O NOT use retired)	Ü	Orking	Ι.		
9	ed will Hygie other ent, th	Be (17. Father's Name (First, Middle, Last)		regi	stered n		ame (First, Middle		ospital Sumame)	
lan	be fill lental rked ic ev	욘	Frank W.Bowders, Jr.					r R. Mor		, Gamano,	
ary	should and M is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Street				or Town, State, Zip	Code)
Σ.	nd 2 sealth m 27		Matthew W. Compher			Maple St	. Way	nesboro,	PA	17268	
ior.	ge 1 a it of H if ite or oth		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from	State C6	emetery, crei	osition (Name of matory or other plac		Date	l	_ocation - City or	
Ħ	it. Pag irtmen irtant: njury		4 ☐ Donation 5 ☐ Other (Specify)	Park	lawn :	Mem. Gard	ens Dec	.11, 201	b c	Chamberst	ourg, PA
Ba	permi Depar Impo any ir once.		21. Signature of Funda Service Licenses			50 S. Bro					al Home, In
			23a. Part 1. Enter the disease, or complications that	caused the death	. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory a	rest,	FA 1/2	Approximate
-4	nysician/	0 4	shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition	ich line.	inti	Cennic	2			1	Interval Between Onset and Death
	Medical Examiner		resulting in death)	or as a conseque	en c of):	CCIVIIV					
		-	Sequentially list conditions, b.								
	ed sit	Examiner	if any, leading to immediate Cause (Disease or iinjury	or as a conseque	ence of):						
	xecut		that initiated events c	or as a conseque	ence of):						
9	ificate be executed og physician and as the burial-transit	Medical	d								
	ag ⊈		IF FEMALE:								
Box 6	death cer attendii ed for use	ian/	23b. Was decedent pregnant in the past 12 months?	come of pregnan Birth 2 Fetal	death 3	Ectopic pregnanc	y		- 1	23d. Date of deli Month	very Day Year
<u>й</u>	law requires that the death cert has been signed by the attendir le 2 should be detached for use	Physician/	1	nant at time of de nown	eath 5 L	Other (specify)				WOITH	Day Tour
P.0	that the ned by detain	by PI	Part II. Other significant conditions contributing to d	eath but not resu	Iting in the u	ınderlying cause giv	en in Part I.	23e. Did 1	obacco	use contribute to	the cause of death?
ds,	requires that the been signed by the should be detach							_ 1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
Records,	law re nas be e 2 sho	Completed						24a. Was	psy	prior to c	opsy findings available ompletion of cause of
Ye.	The ate pag								ormed?	death? 1 ☐ Yes	2 1 No
ita :	sician certifi rector	Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No Hospital:			Othe	ace of Death (Ch				
<u></u>	Phys or this eral di	e: 10	27. Mann Death 28a. Date		28b. Time of	π 3 □ DOA [4 L Nursing	Home 5 Resi			fy)
uo :	arth. r: Afte	icat	2 Accident Investigation	th, Day, Year)	injury	M 1 □	? Yes 2□No		,	,	
Division of Vital	or Atter frer de irecto n by th	Certificate:		of Injury - At honing, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (nd Number or Rura	al Route Number,
בֿ	pital o				de de alle			4			
:	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base only one) 3 Certifying Nurse Practioner:	is of examination	and/or inves	tigation, in my opinic	n, death occurre	d at the time, date	and plac	e, and due to the c	ause(s) and manner stated.
1	To th Withir To th COMP		29b. Signature and title of certifier	2 2 2 2 3 1 1 1 9	1 -	29c. License			29d. Da	ate signed (Month,	, Day, Year)
			1 Jahren Jany	e 1	4.17	PZ	25670	6	1)6	C 06	2010
	10		30. Name and eddress of person who completed caus	e of death (Item		Print)	Baltin	noce 1	1D	2120) }
	Stat	e	Option Action	egistrar's Signatu	ire .		J. (1 (1)	, ,		V V	1
	Registra		DEC 21 2010 2	va B.	Jan .	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ankie Dickens		State of Maryland / Dep 1-For State C Registrar	oartment of e <i>rtificate of</i>		and Mental		Reg. No. 20	10 4036			
Physicia	an/	Decedent's Name (First, Middle,Last)			<u></u>	2. Date of Dea	ath	3. Time of Death			
edical Exami	ner	Frankie Lee Dickenson 4a. Facility Name (if not institution, give street and number)		b. City. Town.	or Location of De	Month December	er 7, 2010 4c. County of	0314 hrs			
		Calvert Memorial Hospital		Prince Fr			Calvert				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 215-15-9053 1 M 2 F 39	. last birthday) Yrs.				irth(MM/DD/YYYY) 10 1970	9. Birthplace (State or Foreign Country) Maryland			
any		Usual Residence of Decedent 10a. State	ty, Town or Locati	on				10d. Inside City Limits			
	_	W. Va. Hampshire	Augusta					1 Yes 2 No			
Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip Code		1	10g. Citizen of What Country?				
th the 23a or		1002 Trails End			704			d States			
eath wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?			Hispanic Origin? (ban, Me xican, Pue	Specify Yes or No rto Rican, etc.)	o- 14. Race - White,	American Indian, Black, etc. White			
after d	by F.	3 Widowed 4 Divorced of 11 Yes 2 ⋈ No	1	Yes 2	No s <i>pecify:</i>		Specify:	while			
hours natur	E E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			pation (Give kind ife. DO NOT use i	16b. Kind of Busi	ness/Industry				
036 thin 72 ne. than '	Completed	12	Stone	Mason			Maso	nry			
215-00 be filed wintal Hygier rked other ent, the M	Be Cor	17. Father's Name (First, Middle, Last) Eddie Lee Dickenson	·		18.Mother's Na Eliza		Maiden Surname) an Oaks				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	스	19a. Informant's Name/Relationship (Type, Print) Ronald M. Pelton / Friend	1002	Trails	End, Au	gusta, W	mber, City or Town, est Virgi	nia 26704			
of Hear Ire		1 Burial 2 Cremation 3 Removal from State	Place of Disposi crematory or oth	er place)	1 1 1 1 1 1 1 1 1	Date	20c. Location - C				
timent rement:		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	aytonsvi		-1	12/14/10	, and the second	ville, Md.			
Ba Depa Injur		Ros W. Barrer	22.17	Murie P. O.	T H. Bar Box 50	ber Fune 38. Layt	ral Home onsville,	Md. 20882			
Physician	ヿ	23a. Part I. Enter the disease, or complications that caused the dea failure. List only one cause on each line.	th. Do not enter th	e mode of dyir	ng, such as cardia	c or respiratory an	est, shock, or heart	Approximate Interval 8etween Onset and			
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Oxycodone Introduction of the control of th		on and	Cocaine	Use		Death			
		Sequentially list conditions, b	or <i>y.</i>								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	of):								
ed sit	Xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence									
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and pitelely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledical	d									
760, cate be physici		IF FEMALE: 23c. If yes, outcome of pre	,				23d. Date of de	elivery			
Box 68760, death certificate be the attending physical for use as the burst of	sician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of a	teath -	al death er (Specify)	3Ectopic preg	nancy	Month	Day Year			
BOY e death the atte	Physi	1 Yes 2 No 9 Unknown 9 Unknown						·			
ires that the signed by	۾	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying caus	e given in Part I.			re to the cause of death? Probably 4 V Unknown			
rds, require been sig	Completed			=		24a. Was		re autopsy findings available			
ecol he law ite has l	E C					autor perfo 1 ✓ Yes	rmed? dea	or to completion of cause of ath? Yes 2 No			
tal Rec	Bec	25. Was case referred to medical examiner?		26.Pla	ice of Death (Che						
Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	١	1 ✓ Yes 2 No	ER/Outpatient		Other Nur		Residence 6 how injury occurred	Other:			
anding Ph tth. r: After t	Ë	1 Natural 5 Pending (Month, Day, Year)	2:30am	1	Yes 2 X No	unknow	• •				
Division pital or Attentours after deatheral Director:	Certification	2 Accident Investigation 3 Suicide 6 X Could not be 12-6-10 28e. Place of Injury - At			e building, etc.	28f. Location (Street and Number	or Rurat Route Number, City			
Spital hours a neral I	히		ate dwel	Lling				vert Co, Md.			
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edica	one) 2 Medical Examiner: On the basis of examination and manner stated.	= :	on, in my opini	on, death occurre		and place, and due	to the cause(s)			
	2	29b. 87ghatore and title of certifier			nse number C. M .E.		29d. Date signed December 7,	(Month, Day, Year)			
	}	2550111001 7									
		30. Name and address of person who completed cause of death (Ite Laron Locke MD. Assistant Medical Examiner	•	Street, Bal	timore, MD 21	1201					
Sta Regist	ate rar	31. Date filed (Month General) 1 2010 32. Redistrar's Signa	ture . Asa	ald.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Marie Dippold Month 500 M 7 brember Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Season's Hospice @ Northwest Hosp. Randallstown Baltimore 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8 Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours 9/11/1926 216-20-9977 Director 84 MD Usual Residence of Decedent show 10b. County within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No La Plata Charles 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1322 Redwood Circle 20646 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working id Mental Hygiene. marked other than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Robert Drawer Marie Graf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vance F. Dippold, Jr./son 1322 Redwood Circle, La Plata, MD other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or 4 ☐ Donation 5 ☐ Other (Specify) Christ Lutheran Cem. 12/17/2010 Dundalk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Cancer Physician/ Lung disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 ☑ 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ê Hospital: 2 🗹 No 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Prineral Director: 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗓 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier 29c. License number 2 nskyapahon M.O 29d. Date signed (Month, Day, Year) DO057465 12/1//0 20

Registrar

31. Date filed (Month, Day, Year)

DEC 0

-5-203, Baltimore, MD. 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of I	Marylan		artmen <i>tificate</i>			and M	lental Hy	giene		1 100	0 6 3
			Registrar 1. Decedent's Name (First, Middle, I	l not)		Cer	uncate	OIL	<i>jeath</i>			Reg. No.	UIL) 400	000
	Physicia	an/									Date of De Month	Day	2010	3. Time of	
	Medi		Kenneth Earl D		-4						Decemb				5 A. M
	Examir	ner	4a. Facility Name (if not institution, g						Location o	of Death			County of Dece cil	ath	
No. amount	-		Calvert Manor H 5. Social Security Number 6		Age (In yrs. I		If Under	ing	Sun If Under 2	24 Hrs I	8. Date of Bir			irthologo (Ctato e	. Faraian
п	Funeral Director		204-26-9237	1 X M 2 □ F		75 Yrs.	Months	Days	Hours	Min.	Dec. I	Year) 9	34	irthplace (State or ountry) PA	r Foreign
			Usual Residence of Decedent		,,,						Dec, 1				
	De State 10b. County 10c. City, Town or Location											10d. Inside Cit	ty Limits		
	Mary 28a-f otifie	ec	NJ Burlin	gton	Bev	erly								1 ☐ Yes	2 💢 No
	10e. Street and Number 10f. Zip Code 10g. Citizen of What C											Country?			
											SA				
												erican Indian,			
36	after ", or camii	<u>b</u>	1 X Never Married 2 Marrie	d 1 Yes 2 If Yes, Give			☐ Yes 2			,	, ,	9	Black, Wh		
21215-0036	ours a	Completed by	3 Widowed 4 Divorced 15. Decedent?	Year or Dates										hite	
15	72 h n "na Aedio	du	(Specify only highest	grade completed)		16a. Deced	ient's Usua kind of worl O NOT use	k done d		of workir	ng	16b. Kin	d of Busines	s Industry	
12	ithin iene.	្រូ	Elementary/Seconday (0-12)	College (1-4 c 5+	or 5+)	Educa		retireu)				Priv	ate S	chools	
p	led w Hyg othe	BB	17. Father's Name (First, Middle, Las			,			18. Mothe	er's Name	(First, Middle,	L			_
Maryland	l be fi lenta rked tic ev	P	Kenneth Earl Di	etrich					Bland	che :	Broughe	er			
ary	hould and M s ma		19a. Informant's Name/Relationship	•		19b. Mailin	g Address	(Street a	nd Numbe	r or Rurai	Route Numbe	r, City or To	own, State, Z	(ip Code)	
	d 2 salth a last 127 i		Richard L. Funk/	Personal	Rep.						21917				
Baltimore,	1 an of He item		20a. Method of Disposition		20b. P	Place of Dispo emetery, cren	sition (Nam	e of	9)		ate	20c. Loc	ation - City c	r Town, State	
E	Page nent ant: It		1 X Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			. Foar			11.	2-8- P		Rici	na Sun	. Marvla	and
alti	permit. Departr Importa any Inju		21. Signature of Funeral Service Lic	ensee											illu
Ω	8 3 5 6 8		Kichard X.	Cloudie		l	11 s.	Que	een S	eral t. R	Home, ising'S	Sun, 1	4D 219	11	
			23a. Parl 1. Enter the disease, or co shock, or heart failure. List onl	omplications that caus	sed the death	h. Do not ente	r the mode	of dying	, such as c	cardiac o	r respiratory ar	rest,		Approximate Interval Betv	veen
	Immediate Cause (Final disease or condition													Onset and D	
	Medical Examiner	Medical resulting in death) Due to (or as a consequence of):												1	~>-
	Lxammer	<u>_</u>	Sequentially list conditions,	b											
	p ‡	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequ	ience of):									
	and and -trans	Examiner	Cause (Disease or ilinjury that initiated events resulting in death) Last	c. Due to (or a	s a consequ	ience of:								-	
	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director. After this certificate has been signed by the attending physician and feural Director. After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical E	roodking in dodkiny Edot												
760	phys phys	ğ		d											
687	ding se as	ĮΣ	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								25	3d. Date of d	olivery	
Вох	atter for u	cial	in the past 12 months? 1 Yes 2 No	1 ☐ Live Birtl 4 ☐ Pregnan			Ectopic polyone Cther (spe		/			20	Month		ear
B	that the dea ned by the a detached t	Physician/Med	9 Unknown	9 🗌 Unknow	n										
P.O.	that the ned bedets	by P	Part II. Other significant conditions	s contributing to death	but not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	obacco use	contribute t	o the cause of de	eath?
S,	v requires that s been signed k should be det	ed									1 🗆	Yes 2	No 3 🗆 1	Probably 4 🗆 U	Jnknown
Records,	w rec	Completed									24a. Was		24b. Were a	utopsy findings a completion of ca	vailable
3ec	The law ate has page 2 a	E O									autor perfo	rmed?	death?	es 2 \square No	use of
a	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Pla	ce of Death	h (Check		2 0 110			
of Vital	Physician: this certificant al director, I	2	1 Yes 2 PNo	Hospital:	atient 2 🗆	ER/Outpatien	t 3 🗆 DO	A Othe	r: 4 🗷 Nur	rsing Hor	ne 5 🗆 Resid	dence 6	Other (Spe	cify)	
of	ding Phi th. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of in (Month, D		28b. Time of injury	28	lc. Injury work?	at		8d. Describe h				
ion	tendil eath. or: Ai the fu	liji Liji	2 Accident Investigat 3 Suicide 6 Could no				М		Yes 2 🗆	No					
Division	or Att	Certificate:	4 Homicide determine	28e. Place of I	njury - At ho etc. <i>(Specify)</i>		et, factory,	office		2	28f. Location (S City or Tow		Number or Ri	ural Route Numbe	er,
Ö	oital o			l l											
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: After completed filled in by the fu	Medical	(Check 2 L Medical Exa	hysician: To the best miner: On the basis of	f examination	and/or invest	igation, in m	ny opinior	n, death occ	curred at	the time, date a	nd place, a	nd due to the	cause(s) and mar	ner stated.
	To the I within 2 To the I comple	Σ	only one) 3 L Certifying N 29b. Signature and title of certifier	urse Practioner: To the	ne best of my	knowledge, d		ed at the License		and place	, and due to the	- ' '		s stated. th, Day, Year)	-
	⊢≶⊨ő		Dia-1	****					4313			12	1 4	12010	
			30. Name and address of person wh	o completed cause of	death (Item	23a) (Type P						, -	1 -		
	10		Joseph Wilner	/	May a	1 Lieu	Risin	Su	MD	219	11				
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signat	23a) (Type, P Ulyuure J. A)							
	Registra	ar	DEC 0 8	3 2010 Den	wa	B. A	racks								

DHMH 17 Rev 7/2009

		State of Maryland / [•		gible.	
		- State Registrar	Cer	rtificate of L	Death			leg. No	ulo	.0364
Physici	ian	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
/Medi	cal	Betty Lee Doolittle 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of		2/6/2		unty of Dea	7:06 A M
Examir	ner	13044 Old Bridge Rd.		Ocean C		Deam			cest	
Funeral	т	Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8	B. Date of Birt	1		thplace (State or Foreign
Director		229-34-2543 1□M 2Ms 83	Yrs.	Worths Days	nours		0/26/			nsas
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Lo	cation						10d. Inside City Limits
Maryl -f sho	ţ	MD Worcester Ocean	Ci	ity						1 □Yes 2√ No
th the or 28a e noti	jrec	10e. Street and Number	of What Co	ountry?						
ath wi	Funeral Director	13044 Old Bridge Rd.	_	21842				US		
er deg items ner m	nue	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Yes, Give	13, V	Was Decedent of His If Yes, specify Cuba	spanic Orig n, Mexican	in? (Speci , Puerto Ri	ity Yes or No- ican, etc.)	14.	Race - Ame Black, Whit	erican Indian, te, etc.
irs aft ir, or xamil	by F	3 Widowed 4 Divorced Year or Dates:		Sp	ecify:	White				
2 hou natura ical E	ted	15. Decedent's Education (Specify only highest grade completed)	. Deced	dent's Usual Occupa	ation	of working	,	16b. Kind	of Business	/Industry
ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done d DO NOT use retired,		Or WOLKING	'			
lled w lygiel ther ti	S	17. Father's Name (<i>First, Middle, Last</i>)	נ' מ.	<u> </u>		r's Name /	First, Middle,		mica mame	<u>L</u>
should be filled within 72 hours after death with the Maryland not Mental Hygiene. In the Maryland should hygiene in matural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	To Be	Robert Adams					Crois		numoj	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	-	19a. Informant's Name/Relationship (Type. Print) 19th	o. Mailin	ng Address (Street a	and Numbe	r or Rural	Route Numbe	r, City or To	own, State,	Zip Code) 21842
and 2 ealth a n 27 is		Sharon Pielert/daughter	mā	13038	01d					City, Md
ges 1 t of H If Iter or oth		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemete	ery, cren	sition (Name of matory or other place	1	Da		20c. Locati	ion - City or	Town, State
it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify) First 21. Signature of Funeral Service Licensee	St	cate Cre	m. 1	2/7/	10	Mill	sbor	DE
perm Depa Impo any I		21. Signature of Pureral Service Licensee	1	2. Name and Addres	i am	Bur S+	bage Ber1	Fune:	ral H	Home
		23a. Part1. Enter the disease, or complications that caused the death. Do shoot, or heaft failure. List only one cause on each line.							110 2.	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	126	oth,						Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence	of):						. <u>.</u>	
Examiner *	<u>~</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of):							
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	.,							
be executed ician and burial-transii		resulting in death) Last Due to (or as a consequence	of):							
w requires that the death certificate be executed the bear signed by the attending physician and should be detached for use as the burial-transit	jical	d								
certific ding p	Physician/Medi	IF FEMALE: 23c. If yes, outcome pf pregnancy						004	Data at da	li
eath (atten	cian	in the past 12 months?		Ectopic pregnancy Other (specify)				230	Date of de Month	Day Year
t the c by the ached	hysi	1 Yes 9 No 9 Unknown 9 Unknown								
es tha gned	by P	Part II. Other significant conditions contributing to death but not resulting i	n the ur	nderlying cause give	n in Part I.			~	,	o the cause of death?
requir een si rould	ted						101	es 2	% 3∐P	robably 4 □Unknown
a 5 0	Completed						24a. Was autor		4b. Were a prior to death?	utopsy findings available completion of cause of
in: Th ificate or, pag		25. Was case referred to medical			OC Diago	of Dogth	1□ Yes	554No	1 ☐ Yes	s 217Na
ysicia is cert directe	To Be	examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/Ou	utpatien	nt 3 DOA Othe	NP.	rsing Hom	-1	lence 6	Other (Spe	ecify)
ng Ph fter th neral			Time of Injury	f 28c. Injury Work	at		3d. Describe I			
tendii leath. tor: A the fu	catic	2 Accident Investigation			/es 2□N					
l or Al after o Direc	Certification:	3 ☐ Suicide 6 ☐ Could flot be determined 28e. Place of injury - At home, fa building, etc. (Specify)	arm, str	eet, ractory, onice		28	City or Tov		umber or H	tural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination at and manner stated.								
To the within To the comple	Med	29b. Signature and title of certifier		29c. License	-			29d. Date s	igned (Mon	th, Day, Year)
		30, Name and address of person who completed cause of death (Item 23a)	(Type		62	78		12	17/1	10
246		David (well, ND Courted +	105		Box	173	3 5	115/-	MD	21802
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	B	6	•))	
Regist		DEC 0 7 2010 Jenus &	1. 6	Farke						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year DeWitt Larry Gay 2010 12:25 Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick College View Center Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 F Days Hours Country) 218-50-0116 Yrs. **Director** 60 07/15/1950 North Carolina Usual Residence of Decedent 28a-f shov 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 🗌 Yes 2 😾 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 13210 Meders Lane, NE 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 🔀 Married Black, White, etc. Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Corporal State Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Gay DeWitt Winona and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a Mary DeWitt / Wife 13210 Meders Lane, NE, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important; If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Pleasant Valley Cemetery 12/11/2010 4 ☐ Donation 5 ☐ Other (Specify) Oakland, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Adams Family Funeral Home. 404 Decatur Street, Cumberland, MD 23a. Part 1. En ... the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine dise as cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burlal-tran resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No the Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autonsy certificate 2 No 1 🗌 Yes Yes **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending I hours after death.
uneral Director; Aftered filled in by the fun Natural iniury work? 2 Accident 2 🗌 No Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 lonte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

10583 THEODORE GREEN BLVD. WHITE PLAINS MD 20695

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Lesera

VIDYASAGAR ANMANDLA, MD.

2

10-09479 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cynthia Ann Dilks State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day December 9, 2010 **Medical Examiner** 1735 hrs Cynthia Ann Dilks 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 44 Willow Court Cecil 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** 9. Birthplace (State or Foreign Maryland Months Director Days Hours 2 X F 212-88-0811 1 M 39 Yrs 05/21/1971 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 X No Maryland Cecil Elkton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44 Willow Court 21921 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No 3 Widowed 4 Divorced Yes, Give Year 1 Yes 2 X No specify: ģ White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Larry Milford Dilks Ella Pauline Eldreth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) မ 19a. Informant's Name/Relationship (Type, Print) Thomas G. Dilks/Brother 321 Buttonwoods Road, Elkton, MD21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State December crematory or other place) 1 Burial 2 X Cremation 3 Removal from State R. A. Ferris & Co., Inc. 15, 2010 West Chester, PA 4 Donation 5 Other Specify: 22 Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Mixed Drug Intoxication (Morphine, Fentanyl, oxcodone Death Immediate Cause (Final disease Examiner or condition resulting in death) and Diazepam) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical attending physician or use as the burial -X UNPENDED AMENDED 23a, 27 the Hospital or Attending Physician: The law requires that the death certificate be 28a-f, per ME G911 Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed has been si 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of page 2 performed Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Director: 1 Yes 2 No unk. Pending fd.12/9/10 fd.5:20pm 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 28f. Location (Street and Number or Rural Route Number, City 3 Suicide or Town, State)
44 Willow Ct. Elkton, MD 24 hours a determined (Specify) Residence Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Cal within 2 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 10, 2010 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 8:20PM 12 2010 Gladys Ruth Elseroad /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Long View Nursing Home Manchester Carroll 7. Age (In yrs. last birthday)
79 Yrs. 6. Sex If Under 1 Year | If Under 24 Hrs. Date of Birth (Month Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2**X** □ F 220-26-6093 **Director** MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Director 1X Yes 2 □ No MD Carroll Manchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3332 Main St. 21102 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ∐Yes 2 [∑] If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **X**No Baltimore, Maryland 21215-0036 than "natural", or 1 □Yes 2XNo Specify. 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important; If item 27 is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oliver LeRoy Farver Ella Mae Warfield ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Johns/daughter 22 Heritage Drive, Hanover, PA 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Sandy Mount Cemetery 12/06/2010 Finksburg, MD 21. Signature of Funeral Service I cen 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA no 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Year 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 2 No . Were autopsy findings available prior to completion of cause of death? has this certificate 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760, Division of Vital Records, ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t filled in by the

To the 1 within 2 To the 1

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

on MD

32. Registrar's Signature

State Registrar

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Canber 0812 AM Donald. Gene Everett Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia **Funeral** 8. Date of Birth Days Hours Min. (Month, Day, Yea /12/1941 1 XM 2 □ F Months Director 236-64-8435 69 Usual Residence of Decedent show 10b. County within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Winding 0ak Dr. U.S.A. 21740 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner rmed Forces? Yes 2 (Yes, Give Black, White, etc. 9 ð 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: "natural", Completed 3 Divorced 4 Divorced Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willard R. Everett Lo1a Μ. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Anne Everett / Wife 234 Winding Oak Dr. Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) MSVC-Roc<u>ky Gap</u> 12/10/2010 Flinstone Maryland e of Funeral Service Lic 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Atheroschool Physician/ Cardio voscu disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last use as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 1 ☐ Yes 2 ☐ No 3 K Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy performe death? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 잍 1 Yes 2 No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

05H2+1

within 2

State

DHMH 17 Rev 7/2009

only one)

29b. Signature and title of certifier

AR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. Liçense numbe.

D28365

Heigestown

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Rember Physician/ Year 3:37 2010 Donald. Ellsworth Foster Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number If Under 8. Date of Birth 7. Age (In vrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) Funeral 1 **№** M 2 □ F Months Days Min (Month, Day, Year, 8/26/1915 Hours Yrs. Director Pennsylvania 217-09-9883 Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗌 Yes 2 🔼 No Maryland Washington <u>Williamsport</u> ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be Funeral items 23a 16505 Virginia Ave. U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 No Completed 3 ₩Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other frammer. Elementary/Seconday (0-12) College (1-4 or 5+) unknown Manager **Electrical** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry N. Foster Alda Shue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl H. Lesher / Niece 12077 Forge Hill Rd. Orrstown, PA 17244 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 12/8/2010 Hagerstown, Maryland Rest Haven Cemetery 21. Sign auro f Funeral Servici 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury -transit To the Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last burial physician s the burial Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No g 🗌 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After t 28d. Describe how injury occurred 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Accident Suicide Investigation the 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

within 24 hours after de To the Funeral Directo completed filled in by the

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD Registrar's Signature

1/ Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year les D 9:00a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OVP 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. Sept 17, Year 1926 217-20-8820 84 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item." any injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carrol1 Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6509 Carroll Highlands Road 21784 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, was becedent Ever in 0.5.
Armed Forces?
1 ☑ Yes 2 ☐ No WW I I
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🕅 No Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) tiling tile setter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richie Lee Howes Charles David Gillis Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5802 Hickory Rd., Stewartstown, PA 17363 19a. Informant's Name/Relationship (Type, Print) Nancy L. Kehring (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Lake View Memorial 1 M Burial 2 Cremation 3 Removal from State 12 - 7 - 10Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Paige Haight P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mesothe Physician disease or condition + 12,7916-12-216 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death isigned by the all fid be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed Yes 1 🗌 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 2 MZ 10

State Registrar

Medical

29a. Certifier

only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

lame and address of person who completed cause of death (Item 23a) (Type, Print)

💴 🗲 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley Godman Dorothy 2010 2:00 A.M December Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Country House Residences . Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Days Hours 1 ☐ M 2 🟋 F 214-18-2570 87 Director 03/03/1923 Maryland Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director PΑ Bedford Everett 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 484 Calhoun Road 15537 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 State Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Sarah Elizabeth (Unknown) Krouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 484 Calhoun Road, Everett, PA Cynthia G. Jett / Daughter 15537 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Vet Cem @ Rocky Gap 12/07/2010 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. — er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death ENILE Immediate Cause (Final DEMENTIA Physician/ disease or condition resulting in death) 471. Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a sonsequence of: death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No Month Day Year Pregnant at time of death 1 Yes 2.5 signed by the a a I Inknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Ves 2 No certificate 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 🕅 Other (Specify) Assisted 1 Tes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

MLS

Medical

Registrar

29a. Certifier

(Check

29b. Signature and title of ce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene Nallin, M.D.,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0034812

909B Seton Drive, Cumberland, MD

29d. Date signed (Month, Day, Year) December 6, 2010

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 1 Florence Helen Goodrich 2010 0802 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harmony Hall Retirement Community Columbia Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 1 F Months Hours May 17, 1928 Director 216-24-7681 82 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Howard Columbia 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10667 Green Bough Ct. USA permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumation. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1≥Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify. Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Administration 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jesse William Goodrich Florence S. Faulkner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Wilhelm 10715 Taylor Farm Rd. Woodstock, MD niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 🗷 Burial 2 □ Cremation 3 □ Removal from State 12/13/2010 Baltimore, Maryland oudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Dicensee 22. Name and Address of Facillarry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, each go of immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of: Exami Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Vear signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2. No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) A55, W 1 ☐ Yes 2 ☑ No Hospital Live Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence Control Other (Spe 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗀 No Accident 1 Tyes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 7 Certifying Nuyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number MD S-ite 103 Colubin 30. Name and add of person who completed cause of death (Itam 23a) (Type, Print) 8 Hugy 633 02115 1 edan an

State

Registrar

31. Date filed (Month, Day,

Year

8

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Year DECEMBER 6, HOWARD FRANKLIN GARDNER, SR. 5:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **QUEEN ANNES** STEVENSVILLE 1021 ROMANCOKE ROAD If Under 1 Year If Under 24 Hrs. 8, Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days Hours Year) SEPT. 14, Yrs. MARYLAND **Director** <u>219-34</u>-3903 1939 Usual Residence of Decedent 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location Director 10d, Inside City Limits 28a-1 **QUEEN ANNES** STEVENSVILLE MD 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 1021 ROMANCOKE ROAD 21666 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 9 þ 1 Never Married 2 X Married 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced 4 Divorced Specify WHITE al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION **ESCAVATION** alth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, မ CLARENCE GARDNER ELIZABETH TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau MARGARET GARDNER/WIFE 1021 ROMANCOKE ROAD, STEVENSVILLE, MARYLAND 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State DEC. Dato. 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) STEVENSVILLE CEMETERY 2010 STEVENSVILLE, MARYLAND 21. Signature Mera∤ Service Licensee ELLIOWS MEETENBEIN & NEWNAM FUNERAL HOME, P.A. 06 SHAMROCK ROAD, CHESTER, MARYLAND, 21619 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ Obstructive disease or condition resulting in death) hrunic ulmoner Medical Due to (or as a consequence of): Examiner Sequentially list conditions. day, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be the attending IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the a d be detached f 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ heart tan lure Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an has autopsy performed?

1 Yes 2 K No prior to completion of cause of death?

1 Yes 2 No this certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No 1 🗌 Yes မ funeral dir 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 55127 2011

Registrar
DHMH 17 Rev 7/2009

State

Centreville,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

202 Coursevallel Drive

31. Date filed (Month, Day, Year)

Suite 101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dec 06 2010 Day Vear 8:40 P **Physician** Joseph Weslev Raymond Hall /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Frederick Calvert Calvert Hospice House 8. Date of Birth Feb 24 1990 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. Months Mary Tand 1 🙀 M 2 🗆 F 20 220-27-3878 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Maxical Experience must be readily of 1 ☐ Yes 2 € No Prince Frederick Director Maryland Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20678 United States 1175 Mallard Point Road Funeral death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐Yes 2 ☐No Black White etc 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Pm 27 is marked other than "natural", or iter 1 □Yes 2 2 If Yes, Give Year or Dates: 1 Never Married 2 Married white 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: q 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) never worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Harold Hall Vickie Lynn White ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. 1175 Mallard Point Rd. Prince Frederick MD 20678 Joseph H. Hall - father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec 9 2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Southern Memorial Gardens Dunkirk Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility of Funeral Service Licenses Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Epidural and Intracerebral Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hemorhilia (Factor 8 deficiency) Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. signed by the a d be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 Respiratory insuffiency 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes Physiclan: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specification House Hospital: 1 ☐ Yes 2X☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27, Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ie Hospital or Attending P 24 hours after death. ie Funeral Director: After t After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titl Dec 6, 2010 completed cause of death (Item 23a) (Type, Print) 30. Name and add Prince Fuel, MY lode W Kaymon 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Elizabeth Harry 2010 December 9:55 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2606 Cove Point Road Lusby Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Months Days Hours Min. 05/27/1954 Maryland 218-50-7227 56 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Lusby 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 2606 Cove Point Road 20657 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Artist Art Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file lith and Mental H 27 is marked o Charles Rudolph Geilfuss Mary Evelyn Bolton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health Donald B. Harry - Husband 2606 Cove Point Road, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If its any injury or of 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 12/9/10 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Rausch Funeral Home, P. A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Metastaha panereani cance Physician year Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 Yes Yes 2 IN Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No ္ဝ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56024 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick MD) Suite 110 L. Aslort 110 Hospital Road Kenneth 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George Luther HENSON 3:35 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 216-22-9167 1 🔽 M 2 🗌 Hours Min Oct. 25 83 ^{Year} 19<u>27</u> Director Maryland Usual Residence of Decedent or items 23a or 28a-1 snorminer must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Washington Hagerstown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9714 Chapelwood Lane 21740 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 2 No 1945 Baltimore, Maryland 21215-0036 1 X Yes If Yes, Give "natural", 1 ☐ Yes 2 K No Specify. 3 X Widowed 4 Divorced 1947 white Completed Specify: Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) correctional officer Õ State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Leroy Henson permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic. Ethel Fridinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Sadehvandi - daughter 9714 Chapelwood Lane, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 2010 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery Hagerstown, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home halit 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ARYNGER disease or condition MONTE Medical resulting in death) Due to (or as a consequence of): Examiner MONTUS. MISTA STATE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit CONGESTIVE HEAR YEMM. that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Day Year 2 🗌 No the detached 9 Unknown P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? pe Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed?

Yes 2 2 No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 (No Other: Certificate: To ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Tyes 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29c. License number Date signed (Month, Day, Year) idu MO 1656 06 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13H H+1 GHA ZAZA (com) MT MAGENSTOWN FINA

State

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elizabeth Heavner Margaret 6:40 A M 2010 December Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Devlin Manor Health Care Center Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 T (Month, Day, Year) 08/13/190 Country) Maryland 103 217-14-4798 Director Usual Residence of Decedent should be filed within 72 10.0...
I and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-1 5...

After a control of the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 Yes 2 X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21502 Funeral 12304 McMullen Highway 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Was Deceson. __ Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other. Gormer Shipe Ada Alice Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 Cedar Road, Pine Knoll Shores, NC 28512 William Pitzer, III/ Grandson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cumberland, MD 12/06/2010 Rose Hill Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, F. . . . 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying that the death certificate be executed Cause (Disease or linjury Levelen -tran that initiated events resulting in death) Last Due to (or as a consequence of) bunialnding physician Physician/Medical Records, P.O. Box 68760 the as use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Vear Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No Yes 2 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Yes 2 HNo Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. injury at 28d. Describe how injury occurred To the Hospital or Attending ■ Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 6, 2010 Wellin ha D17565

M&State

31. Date filed (Mar

ar Kand

32. Registrar's Signature

922 National Highway, LaVale, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony J. Bollino, Jr., M.D.,

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Richard Travis Jackson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Rayenwood illage Lutheran Hagerstown If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 □ F Director 214-32-4227 8/6/1931 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at Director Maryland | Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or filed within 72 hours after death with 18444 21740 U.S.A. Woodside Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ACKSON, RICHAR 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technician is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental Elwood C. Jackson Ella R. Dehart ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra once. Brenda L. Johnson / Daughter 2539 Harpers Ferry Rd Sharpsburg, Maryland 21782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 12/10/2010 Hagerstown Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a const quence of): Physician concer disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an director, page 2 performed? 1 ☐ Yes 2 0 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death.
neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours within 24 hou

To the Fune

completely fi Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) meel street Hagetern 190 21740. MARI AR 31. Date filed (Month Day 32. Registrar's Signature Yea 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

year

1 ☐ Yes 2 No

New Jersey

White

5'00 AM

Year

Black, White, etc.

Cement

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 CNo

Year

2010

3H 3+1

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Dec MINERVA J. KERST 1 Day 2010 10:51 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c County of Death CARROLL CARROLL COUNTY HOSPITAL If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Penna. **Funeral** 216-38-2678 Days Hours 1 □ M 2 🛣 F 72 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examinar must be activitied to 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glen Rock YORK PA 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 17327 Funeral 6881 Grave Run Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last)
John E. Bare 18. Mother's Name (First Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print)
Paul E. Kerst Jr. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6881 Grave Run Road, Glen Rock, PA 17327 husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lazarus Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec.16,2010 Lineboro, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Geiple Funeral Home Inc. #CC0265 Lag <u>53 Main St</u> Glen Rock 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Acute Myo cardial Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arric Aneuvysm-Ascending, Aorna Insufficiency's 1 Yes 2 No 3 Probably 4 Unknown Stage 3 Chronickidney Disease; Breat Gincer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Hypercholesterolemia: Lymnhousta After this certificate 1 Yes 2 No 1 Yes Be 25. as case referred to medical 26. Place of Death (Check only one) examiner? Hospital: |은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury s after deau. work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

completed filled in by 24 hours a

DHMH 17 Rev 7/2009

State Registrar

only one) 29b. Signature and title of certifie

Andre

31. Date filed (Month, Day, Year)

F.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LTOI

MD

Registral's Signature

1001

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

PA

Yorle

December 13,2010

29c. License number

Si George St

Sandra Rence Long

10-09193 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK		S 1- For State Registrar	ate of Maryla	•		ent of ate of		d Ment	al Hy	•	2 0 l	0 40381
Physicia Medical Examii	n/	1. Decedent's Name (First, Midd Sandra	Renee	Long						2. Date of Dea Month Novembe	Day Year er 30, 2010	1437 nrs
		4a. Facility Name (if not institution 9500 H. G. Trueman	. 5	mber)		41	. City, Town, or Lusby	Location of	Death		4c. County o Calvert	f Death
Funeral Director		5. Social Security Number $218-80-5980$	6. Sex	7. Age (In yrs. 43		Yrs.	Months Day		24Hrs. Min.	_	,	9. Birthplace (State or Foreign Country) MD
ow any		Usual Residence of Decedent 10a. State 10b. County	1	10c. City		or Locatio	1					10d. Inside City Limits 1 Yes 2 No
e Maryland or 28a-f show any ied at once.	Director	10e. Street and Number	G. Truem	an Roa	Lus		10f. Zip Code	 5.7		1	I0g. Citizen of Wha	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	uneral	11. Marital Status 1 Never Married 2 K M	12. Was Dec	edent Ever in U			Decedent of His , specify Cubar	spanic Origi				American Indian, Black, etc.
hours after "natural", CExaminer	ted by F	3 Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12)	ecedent's	es 2 1 No Usual Occupate of working life	tion (Give ki	nd of w	ork done ed)	16b. Kind of Bus	,			
, MD 21215-0036 and 2 should be filed within 72 hours after tealth and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner	Completed by	1 2 17. Father's Name (First, Middle	College (1		Employment Team Specialist 18.Mother's Name (First, Middle, N						anization	
21215 uld be file Mental H marked o	To Be (George 19a. Informant's Name/Relations		rrod,		. Mailing /	Address (Stree	He1e			Wallace	, State, Zip Code)
e, MD and 2 sho Health and titem 27 is		Phyllis Dawl 20a. Method of Disposition		20b.	Place of	10 S	on (Name of cer	s Wha	rf	Rd. L	usby, M	ID 20657 City or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 X Burial 2 Cremation 4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	om State Gr	cremato tr		r place) . eway ne and Address					Fred., MD
Physician	-	Decly a. 23a. Part I. Enter the disease, or	Sewell	used the death	n. Do not							Home, MD2067
Medi al Examiner	ĺ	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	e Injuries								Between Onset and Death
	ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as a									
ted 1 msit	Examiner											
0, e be executed sician and burial - transit	edical	UNPENDED	AMENDED			D, C	CHD, 12	/8/20	10,c	lrw		1.2-
Box 68760 e death certificate b the attending physicate but for use as the but		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No g ✓ Unit	1 Live bi	ant at time of de	2		death 3 [Ectopic p	oregnan	су	23d. Date of d Month	lelivery Day Year
D. B. Ithe d		Part II. Other significant condit	a ourio		resulting	in the und	lerlying cause g	iven in Part	i.			ute to the cause of death?
— δ <u>20</u> ຄ	Completed by			-		-			_	1 Yes	an 24b. W	Probably 4 Unknown ere autopsy findings available for to completion of cause of
Recc n: The lav ufficate ha		25. Was case referred to medica					26.Place	of Death (C	Check or	1 Yes	rm <u>ed</u> ? de	eath? ✓ Yes 2 No
f Vil	To Be	examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of	npatient 2		patient :	B DOA	O4	Nursing	Home 5	Residence 6	
Division of Vital Records, raterding Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pend 2 Accident Inves	FOUND: Nov 30, 2	Day,Year) 2010	FOUN 1437	ND: hrs	·	′es 2 ✓ N	lo S	Subject was	stabbed and	
bou hou		4 Homicide deter	a not be	Park/Recr	eation	Area			9	or Town, S 500 H. G. Tr	itate) ueman Road, Lu	usby , MD
To the Hos within 24 h To the Fur	톓		miner: On the basis o and manner st	f examination a				death occu			and place, and du	
		hyh	J. us				O.C.				December 1	
RW 8			nt Medical Exam	niner 111	Penn	Street,	Baltimore, I	MD 2120	1			
Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Signati	ure	1	adi D					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of State of Registrar		oartment of Heal ertificate of Dea			ene2010	4,0382		
	Physicia	in/	1. Decedent's Name (First, Middle, Last)	mic	Linn		2. Date of Death Month	Day Year	3. Time of Death		
_	Medic Examir	cal	Marion Virgi 4a. Facility Name (if not institution, give street and number)		Linn 4b. City, Town, or Loca	2:25 A M					
Same.	Examir	ier	Country House Residence		Cumbe	4c. County of Dea	legany				
	Funeral Director		215-16-4646 1 ^{1 □ M 2 - 1} XF	Age (In yrs. last birthday, 93 Yrs.	If Under 1 Year If U Months Days Hor		8. Date of Birth (Month, Day, Y 07/24/1	(ear) Co	thplace (State or Foreign buntry) ryland		
	show show	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits		
	Maryla 28a-f otified	rect	MD Allegany	C	Cumberland				1 🏿 Yes 2 🗆 No		
	s 23a or	neral D	10e. Street and Number 115 W. Harrison Street	,	10f. Zip Code	1 502	10	lg. Citizen of What Co USA	Citizen of What Country? USA		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show array injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 If Yes, Give Year or Date:	X No	. Was Decedent of Hispanie If Yes, specify Cuban, Me. 1 ☐ Yes 2 汉 No Specify Cuban Specify Roman Specify Roman Specify Roman Specify Roman Rom		fy Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify:			
21215-0036	within 72 hou jiene. er than "natu the Medica		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 12	(Give	edent's Usual Occupation e kind of work done during DO NOT use retired) Secretary	most of working	, 1	6b. Kind of Business Gasolin			
Maryland	id be filed v Mental Hyg arked other atic event,	To Be	17. Father's Name (First, Middle, Last) John Joseph	Good	lyear 18. M	Mother's Name (i Bertha	First, Middle, Ma Eli	zabeth	Frost		
	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship (<i>Type, Print</i>) Kimberly Gabaldoni/Grando	laughter 70							
Baltimore,	permit. Page 1 a Department of H Important: If itel any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	Cumberla	ematory or other place) and Crematory	' i	oc. Location - City or Cumberlan	d, MD			
Balt	permit Depart Import any inj		21. \$ignature of Funeral Service Ocensee		22. Name and Address of F 404 Decatur			-	Home, P.A. 21502		
	Physician/		23a. 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition Alzh			ch as cardiac or r	respiratory arrest	,	Approximate Interval Between Onset and Death O years		
	Medical Examiner	٠.	resulting in death) Due to (or Sequentially list conditions, b.	as a consequence of):							
_	and -transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	as a consequence of):							
09,	cate be executed physician and the burial-transit	dical	d	ao a concesquence co,							
. Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed that 4 hours and redeath. Lat 4 hours and extra death. The Funerial pirector, fleet this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me		th 2 Fetal death 3 nt at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	livery Day Year		
ds, P.O.	pulres that the signed by the	β	Part II. Other significant conditions contributing to deat	h but not resulting in the	underlying cause given in	Part I.			the cause of death?		
Division of Vital Records,	The law require cate has been si page 2 should	Completed					24a. Was an autopsy performe	prior to	topsy findings available completion of cause of		
ital	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 V No Hospital:		_ Other	Death (Check o			Assisted		
n of V	ding Physicia h. After this cert funeral direct	ate: To	27. Manner of Death 1 🔀 Natural 5 🗆 Pending 28a. Date of (Month,	patient 2 ER/Outpatien njury 28b. Time of injury	ent 3 □ DOA 4 L	28	e 5 L Residen d. Describe how	ce 6 🛛 Other (Special Injury occurred	ify) Living		
ivisio	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, Affer th completed filled in by the funeral	Certificate:		Injury - At home, farm, st etc. <i>(Specify)</i>			f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,		
The last of the part of the past of the									cause(s) and manner stated.		
0	Tot with com		29b. Signature and title of certifier Aulthorized The Control of the Control of		29c. License numb D 1756		290	d. Date signed (Monte December			
	nes		30. Name and address of person who completed cause of Anthony J. Bollino,			l Highw	ay, LaVa	ale, MD 2	21502		
	Star Registra	ie.	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	d. I						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 015 a 9 0531AM Nov 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death University of Maryland Me disal leat. 5. Social Security Number 6. Sex 7. Age (In vrs. last birth Altimore If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 07/03/1921 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 544-18-1441 Director **Oregon** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov Director Maryland AnneArundel XIXIYes 2□No Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8504 Summershade Drive 21113 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian filed within 72 hours after 1 ☐ Yes 2/XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; if item 27 is marked other than 'any injury or other traumatic event, the Magnes. 2+^{College (1-4or 5+)} Elementary/Secondary (0-12) Social Worker Volunteers of America 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Julius Hansen ပ Effie Epling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Mills/ Husband 8504 Summershade Drive, Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Beverly Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/03/2010 | Beverly, West Virginia 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of F 16000 Annapolis Rd. Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** JOCARdial /Medical Examiner DroNAry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed Exami and Due to (or as a consequence of) attending physician Physician/Medical the use yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 🗆 Ectopic pregnancy 10 Year Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

State Registrar

Vlatthew 31. Date filed (Month, Day, Year) DEC 0 6 2010

29b. Signature and title of certifier

22 32. Registrar's Signature

and manner stated

mi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D6900321

29d. Date signed (Month. Day, Year)

Greene St. Bakimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year JOE MAYE DECEMBER 10:20 A 5. 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 807 RANDOLPH DRIVE HARFORD ABERDEEN Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 2, 19 5. Social Security Number 7. Age (In vrs. last birthday) Days Min 1 ★ M 2 🗆 F 68 Yrs. 416-58-9379 1942 ALABAMA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No MARYLAND HARFORD ABERDEEN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 807 RANDOLPH DRIVE 21001 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1∐Yes 2XDNo Specify Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONCRETE PIPE FABRICATOR 9 PIPE MANUFACTURE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TED MAYE AGGIE DEE MIXON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) QUINSANNA MAYE / WIFE 807 RANDOLPH DRIVE, ABERDEEN, MARYLAND 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BERKLEY CEMETERY 4 Donation 5 Other (Specify) 12/11/10 DARLINGTON, MD 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 21. Signature of Funeral Service Licensee cott - Colyon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Non small cell Leens 20monThs Due to (o a) a consequence of): Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown

Physician /Medical Examiner

for use

page 2 should

funeral director,

completely

24 hours after death Funeral Director: filled in by the

within 2

Medical Certification: To

The law requires that the death certificate be executed

Box

Ö

Records,

Division of Vital Hospital or Attending Physician; **Physician**

/Medical

Director

Funeral

ģ

Completed

Be

ပ

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Wedical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Media once.

Baltimore, Maryland

2

05

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

23e. Did tobacco use contribute to the cause of death?

Physician/Medical δ Be Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Xes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 1 □Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 🔀 Natural 5 Pending investigation 2/ Accident

6 ☐ Could not be

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

3 Suicide 4 Homicide 29a. Certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

(Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

orsellam M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. SIVASAL 47M, 602 S. Atwood, Suite 200, Belair MD 21014

45530

1 ☐ Yes 2 ☐ No

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ralph Edward McKnight December 2010 00:09 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County E1kton Ceci1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 🕱 M 2 🗆 F Hours Min. Country) Maryland Director 12-70-2424 March 17 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil North East 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 141 Arrants Road 21901 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Equipment Operator Highway Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ralph McKnight Helen Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Molitor / Companion Arrants Road, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8, 2010 Harts Cemetery North East, Maryland 21. Signature of upon since licens 22. Name and Address of FacilityCrouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death PSIS .Fhysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 2120H Sequentially fist conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit HEPA Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical PULMONARY HYPERTENSION Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year 4 Pregnant Pregnant at time of death 5 Other (specify) Day the 1 ☐ Yes 2 L is certificate has been signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy performed Yes 2 X Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🌠 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANMAY SAMAN STREET BOW

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC 08 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2010 Charles Dudley McCready 12:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Dowell 544 Twin Cove Lane 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Mary Land Director 218-24-0077 80 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 M No Dowell Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 544 Twin Cove Lane 20629 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 호 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 Mo Specify: White Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) uepartment of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injuy or other traumatic event; the Manone. Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Salesman Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John E. McCready Grace E. Humphreys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Marlyn McCready / Wife P.O. Box 1035, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary Bible Cemetery 12/13/2010 Lusby, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -Oronan disease or condition resulting in death) 6 year Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year Pregnant at time of death by the a signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b il director, page 2 sl performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) hones w Bennett as D25156 December 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Charles W. Bennett,

31. Date filed (Month, Day, Year)

MD

2010▶

32. Registra s Signature

11845 H.G. Trueman Rd., Lusby, Maryland 20657

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of N	Maryland		artment of F <i>tificate of E</i>	lealth and N Death		giene Reg. No.	0	40387
Physicia	an/	1. Decedent's Name (First, Middle						2. Date of Dea	ath	_Year	3. Time of Death A
Medic Examir	cal	Martha Ma 4a. Facility Name (if not institution,	arie n, give street and number,	Mille	r	4b. City, Town, or	Location of Death	Occemb	4c. County		0625 M
1		Washington Cou			t tak daya	Hager	stown		Was	hingt	
Funeral Director		5. Social Security Number 213–40–4702	6. Sex 7. A 1 □ M 2 💢 F	Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 2	h , Year) , 1919	Countr	lace (State or Foreign ry) vland
nd how at	۲	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Loc	ation					Od. Inside City Limits
Maryla 28a-f s otified	irect		ington	Ha	gersto	wn					1 ☐ Yes 2 🔀 No
death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	10e. Street and Number	ma			10f. Zip Code			10g. Citizen of V		ry?
leath w	Fune	19517 Lorraine 11. Marital Status	12. Was Deceden	e?		Vas Decedent of His	spanic Origin? (Spe	ecify Yes or No-		e - America	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>م</u>	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🛛 Divorced	rried 1 Tyes 2	X No		Yes, specify Cubai	n, Mexican, Puerto Specify:	Rican, etc.,		ck, White, et White	
72 hou an "natu Medica	Completed	(Specify only highe	ent's Education est grade completed)		(Give ki	ent's Usual Occupa ind of work done d O NOT use retired)	ation funng most of worki	ing	16b. Kind of Bu	usiness Indi	ustry
I within ygiene. her tha it, the I	اما	Elementary/Seconday (0-12)	College (1-4 o	ır 5+)		ng Assis			Nursi		me
be filec ental Hr ked otl	To B	17. Father's Name (First, Middle, L David L.	Last) Griffi	th			18. Mother's Name Temmie	e (First, Middle, 1 E •		e) enawa	1d
should and Mr is mar aumat		19a. Informant's Name/Relationsh	hip (Type, Print)		19b. Mailin	g Address (Street a	and Number or Rura				
and 2 thealth tem 27		Joyce Hamilton 20a. Method of Disposition	/ Daughter			7 Lorrai:	ne Terrac	ce Hager	stown,		
Page 1 nent of ant: If it		1 💢 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate ce.	emetery, crem	Cemetery	e)	9/2010			
permit. I Departm Importa any inju		21. Signature of Funoral Souther L	icensee	0	22.	. Name and Addres	ss of Facility Bas	st-Stauf	fer Fun	eral	
		23a. Part 1 Enter the disease, or shock, or heart failure. List o	complications that caus	sed the death.		r the mode of dying	g, such as cardiac c	or respiratory arre	est,		Approximate Interval Between
Physician/ , Medical		Immediate Cause (Final disease or condition resulting in death)	_a _ C	arc	lis;	respi	va tos	y F	arlua	_	Onset and Death
Examiner			bue to (or a	as a conseque	3		se lli			1	tem.
3d isit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or a	as a conseque	ence of):	en si				7	
execute an and ial-tran	Exal	that initiated events resulting in death) Last	c. Due to (or a	as d conseque	ence of):	m 3/1	22	-		- 1	cons
cate be executed physician and the burial-transit	edical Examiner		d								
certifica inding p use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom						23d. Da	te of deliver	rv
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live Birth 4 Pregnant 9 Unknowr	t at time of de		Ectopic pregnancy Other (specify)	У		Мо		Day Year
s that thighed by	<u>&</u>	Part II. Other significant condition	ons contributing to death		Iting in the un	nderlying cause give	en in Part I.				e cause of death?
require been si should	leted				11-0	1 Mais an		1 L Y			ably 4 Unknown
The law ate has bage 2:	Completed	De	hydr.	7:5	2			autops perfor	sy F		pletion of cause of
ician: T certifice ector, p	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death (Check		2 (34)(0)		
g Physier this energles	te: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpa 28a. Date of in	njury 2	28b. Time of	28c. Injury	4 ∐ Nursing Ho at	ome 5 Reside			
tending leath. tor: Aft	Certificate:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation not be		injury		Yes 2 ☐ No				
rtal or At irs after or al Direct lled in by		4 Homicide determ	pined 28e. Place of Ir	Injury - At hom etc. (Specify)		et, factory, office		28f. Location (St City or Town		er or Rural F	loute Number,
he Hospi in 24 hou he Funer	Medical	(Check 2 Medical E	g Physician: To the best of Examiner: On the basis of g Nurse Practioner: To the	f examination	and/or investig	gation, in my opinio	n, death occurred at	t the time, date an	nd place, and due	e to the caus	se(s) and manner stated.
or to						29c. License	number	2	29d. Date signed	d (Month D	
	1 - 1	29b. Signature and title of certifier	1	,		1)3	549-	7	12,		
الله الله		30. Name and address of person v	rhear		23a) (Type, Pr	int)	549-	7 -	12,	6.1	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	ase Type o						-		egible.			
		For State	State	oi iviaryi	and / Dep Ce	rtificate d		anu iv	ленан пу		. 1.0	-00	0.0	
		Registrar 1. Decedent's Name (First, Middle	e, Last)	-		rimouto c	Dodan	-	2. Date of De	Reg. N6	H U	3. Time of	Death	
Physicia Medic		Shirley A. Myer	rs						December 1	er 1, 2	2010	6:30	m __ q	
Examin		4a. Facility Name (if not institution		mber)			n, or Location	of Death			nty of Death		_	
· 		8 Prospect Ave	6. Sex	7 Age //p //	rs. last birthday)	India	n Head	7 24 Hrs	8. Date of Bit		narles	nines Ptato n	- Fauria-	
Funeral Director		220–24–9134	1 ☐ M 2 🔀 F	80	Yrs.		ays Hours	Min.	(Month, De Sept.	23, 193	30 Ma	place (State of rtry) ryland	roreign	
d ow t		Usual Residence of Decedent											. I fantka	
arylan a-f sh fied a	Funeral Director		rles	100.	INdian							10d. Inside City Limits 1 □ Yes 2 □ No		
or 28 e noti	Dir	10e. Street and Number 10f. Zip Code									of What Cou			
s 23a	era	8 Prospect Ave. 20640												
death item		11. Marital Status	12. Was Dec Armed F	edent Ever in prces?		Was Decedent If Yes, specify (of Hispanic Or Cuban, Mexica	igin? (Spe	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,			
al", or	d by	1 U Never Married 2 U Married 1 U Yes 2 W No												
hours natur Jical E	Completed	15. Deceder	nt's Education			dent's Usual O				т — —	cify: Whi f Business Ir			
hin 72 ne. than " ie Mee		Elementary/Seconday (0-12)	est grade completed College (7 1-4 or 5+)	Ìife. L	kind of work do	red)	st of work	ing	D	1 000			
ed wit Hygie other	Be C	17. Father's Name (First, Middle, L	_ast)		Dent	al Assi		ner's Nam	e (First, Middle,		l Off:	ıce		
l be fil fental rked tic ev	입	William C. Abe							larguer:		,			
should and N is ma		19a. Informant's Name/Relationsh				ng Address (Sti					-	Code)		
and 2 fealth em 27 her tr		Rhonda Y. Frey	Da	ughter		5 Sharo		•		T				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from	State	b. Place of Dispo cemetery, cre ark Hil	matory or other	place)		2010		on - City or T		1	
nit. Pa aartme oortan injung		4 Donation 5 Other (S		F							LLY, I'K	aryland	1	
Depar Depar Impo any ir		Mala	Man	M006	68 4	11111ams 270 Haw	Funera thorne	Rd.	me, P.A India	A. n Head.	Md.	20640		
		23a. Part 1. Enter the disease, or shock, or hear failure. List of	complications that only one cause on e	caused the d ach line.		/					,	Approximate Interval Bety	ween	
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	meh		Sul 1	Tynh	tri	BLE	11 typ	()	Onset and D		
Examiner		rooming in domy	Due to	or as a cons	equence of):		- (/	<i>J</i> '		3		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a cons	equence of):									
executed an and rial-transit	Examiner	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of):												
cate be executed physician and s the burial-transit	I — I	resulting in death) Last	Due to	(or as a cons	equence on.									
ficate I g phys	fedi													
n certif ending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pre		☐ Ectopic preq	nancv			23d.	Date of deliv	•		
e death the att hed fo	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pre	gnant at time nown	of death 5 [Other (specif	n)				Month	Day Y	'ear	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bur	by Ph	Part II. Other significant condition	ons contributing to	death but not	resulting in the	underlying caus	e given in Part	ı.	23e. Did t	tobacco use co	ontribute to t	he cause of de	eath?	
luires t	ed b								1 🗆	Yes 2, N	o 3 🗆 Pro	bably 4 🗆 l	Jnknown	
aw rec as bee 2 sho	Completed								24a. Was		prior to co	psy findings a		
The lacate h							-		perfo	ormed? 2 D No	death?	2 🗆 No		
sician certifi rector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	1			6. Place of Dea		V					
g Physer this eral di	e: 1 0	27. Manner of Death	28a. Date	of injury	28b. Time o	f 28c.	njury at		ome 5 A Resi 28d. Describe I			()		
endin eath. or: Aft	ficat	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation	nth, Day, Year,) injury		vork? I Yes 2] No						
or Att	Certi	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place	e of Injury - At ing, etc. (Spe	t home, farm, st c <i>ify)</i>	reet, factory, off	ice		28f. Location (City or Tox		mber or Rura	l Route Numb	e <i>r</i> ,	
spital	Medical Certificate:	29a. Certifier 1 Certifying	Physiciáh: To the	best of my kn	owledge, death	occured at the	time, date and	place, an	id due to the ca	ause(s) and ma	nner as state	ed.		
he Ho in 24 h he Fui ipletec	Med		xaminer On the ba Nurse Fractioner										ner stated	
With With Con t		29b. Signature and title of certifier	1/ /	71.0		_	ense number	,		29d. Date sig	ned (Month,	Day, Year)		
		30. Name and address of person v		00.06.35.11.77	00-17	D-1-1)	3342				5 10			
1812		B I APPLI JEN	KiNS MD	P. O.	Box 2	665 La	Plata	. M	10. 20	646				
Stat		B. LARRY JEW. 31. Date filed (Month, Day, Year)	32.	egistrar's Sig	nature	1 1	. 100.0	-1 -1						
Registra	ar	<u> </u>	3 2010 1	news	12. 14	acke								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year James Spencer Moreland, Jr. 0133 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death WICOMICO alisbur Regional Medical Cente ninsula If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ xM 2 □ F Months Hours Min 213-40-8585 68 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 21811 3 Mast Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, d Forces Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates. ō ģ Never Married 2 ☐ Married Maryland 21215-0036 White 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpentry Carpenter Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Irene Loretta Yountz James Spencer Moreland, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ocean Pines, MD 21811 Mast Court, Laura Moreland/Partner Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Millsboro, 12/7/20104 ☐ Donation 5 ☐ Other (Specify) 1st State Crem. 22. Name and Address of Facility Service Licensee Burbage Funeral Home William St., Berlin, MD 21811 108 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or flear failure. List only one cause on each line. shoo Interval Between Immediate Cause (Final Onset and Death Physician/ otic Shoc disease or condition Medical resulting in death) Du- to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a confequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? performed? this certificate 2 No 1 Yes Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 4 No 1 Yes မ 1 Impatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of Certificate: 28c. Injury_at 28d. Describe how injury occurred or Attending atural 5 Pending work' 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the Malis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signatur ttle of certifier 29d. Date signed (Month, Day, Year)

PH 12+1 State

Registrar

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mC

gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Petate of Maryland / Bepartment of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia Hill Burton Mulligan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 □▼ Year)924 Min. Hours ′Mar™ 213-24-5299 Director 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Allegany Cumberland 28a-f 1 Xes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 1 Baltimore Street, Apt. 310 21502 USA items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 XWidowed 4 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home nit. Page 1 and 2 should be filed with sartment of Health and Mental Hygier octant: If Item 27 is marked other 1 Injury or other traumatic event, the injury or other traumatic event, the same of the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Mitchell Robert Mitchell Hill Leila Katherine (Keim) Hill 19a. Informant's Name/Relationship (Type, Print)
Barbara Clougherty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 6165 Reserve Cir. # 1503 Naples FL Daughter 34119 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2 Femation 3 Removal from State Scarpelli Funeral Home, P.A. 12/3/201b Cresaptown MD 4 Donation 5 Other (Specify) 2 Signature of Funeral Pervice Licensee 22. Name and Actoress of Fernity Property Home, PA 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or cardillice) 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin that the death certificate be executed Due to (or as a consequence of): resulting in death) Last nding physician use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnap 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autonsv death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manual of Death completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural $5 \square$ Pending 24 hours after death. Funeral Director: A ☐ Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. only one) 29b. Signature and

DHMH 17 Rev 7/2009

Registrar

of person who completed cause of death (Item 23a) (Type, Print)

OF T_ I MARUATE. 912 SETON DRIVE CUMBERIAND, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Physician/ Monthov 28, 2010 Year Brenda Ann Sullivan McConnell 2:22 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 102 Wiegand Drive LaVale Allegany 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) D.C. 1 M 2 T (Month Day 0° 1951 **Director** 220-56-1279 59 Usual Residence of Decedent 10a. State 10b. County items 23a or 200 . . . ner must be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Allegany LaVale 1 DxYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Wiegand Drive 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No "natural" Completed 3 Widowed 4 Divorced white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) bank officer bank d 2 should be filed wit alth and Mental Hygie of 1 27 is marked other or traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Robert E. Sullivan Margaret (Camelot) Palyo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
102 Wiegand Drive LaVale MD 21502 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau James McConnell husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Kemation 3 Removal from State Scarpelli Funeral Home, P.A. 11/29/2010 MD Cresaptown 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ metratita nset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month 1 ☐ Yes ∠ ₪ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 -No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy performed this certificate 1 Yes Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 - Natural 5 Pending Accident Investigation 1 Yes 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier E-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00017565 w. 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LaVICe 11/6 Belline 922 N2+1 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please	Type or Pr					-		Legible	
		for State Registrar		State of M	larylan		partment of F ertificate of D			./	010	40392
D I 111	. ,	Decedent's Name	e (First, Middle, La	st)			timodito o. 2	- Cuti	2. Date of De		V	3. Time of Death
Physicia Medic	al			Neumann, J	r.		I		Month 12	Day D3	Year 2010 County of Dear	
Examin	er	Peninsula	, Region	al Madia		Her	501	Location of Death	S. Date of Bir	TV.	nico	
Funeral Director		5. Social Security No. 187–28–59	58	Sex I M 2 □ F						y <i>Year)</i> 935	9. Bir Co Mar	thplace (State or Foreign untry) yland
yland f show ed at	ctor	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits
or 28a- notifii	Director	VA 10e. Street and Nun	Accomack nber		Tas	ley	10f. Zip Code			10a Citiz	zen of What Co	1 Yes 2 No
s 23a o	Funeral	21415 Ch	errix La	ne			23441				USA	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Marr 3 Widowed	ied 2 Married 4 Mivorced	12. Was Decedent Armed Forces? 1 A Yes 2 If Yes, Give Year or Dates.	No		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		4. Race - Ame Black, White Specify: wh	e, etc.
Phours "natur dical B	Completed	(Spe	15. Decedent's Education (Specify only highest grade completed)				edent's Usual Occupa kind of work done a		kina	16b. Kin	nd of Business	Industry
rithin 72 lene. r than the Me		Elementary/Seco		College (1-4 or 2	5+)	Ìife. I	00 NOT use retired) epreneur	army most or work	ung	Reta	ail Sal	es
e filed w tal Hyg ed othe event,	To Be	17. Father's Name (1221020	7710110	18. Mother's Nan				
ould by nd Mer marke		19a. Informant's Na	aul Neuma			19h Mai	ing Address (Street a	Cora F		r City or T	Town State Zin	n Code)
nd 2 sh ealth a m 27 is er trau		Steven P.	Neumann				outh Woods					
age 1 ar ent of H nt: If iter y or oth				Removal from State	9 0	emetery, cre	osition (Name of ematory or other place Crematory		Date /2010		ation - City or	Town, State Maryland
permit. F Departm Importal any injul		21. Signature of Fur		•	Joan	Î	2. Name and Addres	s of Facility	ome. Pro	ofessio	onal Ass	ociation
	Н	23a. Part 1. Enter t	he disease, or com	aplications that cause	d the deat		07 Vine S	t., Poco	moke Ci	ty, M	<u>1D 2185</u>	Approximate
hysician/		Immediate Cause (disease or conditio	Final	one cause on each lin	e. CB12	2 VAS	WLAK	1	CCI DE	-N	T	Interval Between Onset and Death
Medical Examiner		resulting in death)	ſ	Due to (or as	a consequ		-					
ted nsit	Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i	nmediate rlying iinjury	b. Due to (or as	a consequ	uence of):						
e executed cian and ourial-transit	al Exa	that initiated events resulting in death) t		Due to (or as	a consequ	uence of):						
ficate b physical sthe b	Nedic		_	d								
Physician: The law requires that the death certificate be this certificate bas been signed by the attending physic ral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	death 3	☐ Ectopic pregnanc☐ Other (specify)	у		23	3d. Date of de Month	livery Day Year
juires that the series of signed by all the detail	by	Part II. Other signif	icant conditions o	contributing to death t	out not res	ulting in the	underlying cause giv	en in Part I.				the cause of death?
The law rec ate has be age 2 sho	Completed								24a. Was autop perfo 1 Yes	rmed?	prior to death?	topsy findings available completion of cause of
sician: The certificate I irector, page	Be	25. Was case referre examiner?		Hospital:			Otho	ace of Death (Chec		2		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	cate: To	1	5 Pending	1 ☑ Inpat 28a. Date of inju (Month, Da	iry	28b. Time of injury	of 28c. Injury work	4 ☐ Nursing H	ome 5 Residence 28d. Describe h			ify)
al or Atten s after dea I Director: d in by the	Certificate:	3 Suicide 4 Homicide	Investigatio 6 Could not be determined	00	ury - At ho c. (Specify	me, farm, st	reet, factory, office	100 2 2 100	28f. Location (S City or Tow		Number or Ru	ral Route Number,
he Hospita in 24 hours ne Funera pleted fille	Medical	(Check 2		sician: To the best of iner: On the basis of e se Practioner: To the	examination	n and/or inve	stigation, in my opinio	n, death occurred a	t the time, date a	nd place, a	and due to the	cause(s) and manner stated.
Not Tot com		29b. Signature and	title of certifier	Anni		MI	29c. License	number 6057 (29d. Date	signed (Manth	n, Day, Year)
H 15+1		MIHIA	www	completed cause of c	leath (Item	23a) (Type,		SHORE	DR.	SAC	USRL	VCY MO21804
Stat Registra	e ar	31. Date filed (Month	DEC 0 7 2	010 32. Pegistr	ar's Signat	ure Ø. A	harres					
					-							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rov Daniel Nicholson 9:00 A M December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1055 Weires Avenue Allegany LaVale Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ▼ M 2 □ F Months Hours Min. (Month, Day, Year) 03/01/1923 Country) Pennsylvania 193-18-0449 87 **Director** Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD LaVale Allegany 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1055 Weires Avenue 21502 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1942—
If Yes, Give Black, White, etc. 9 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Eventone. 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 1945 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Insurance <u>Insurance</u> Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Silas Nicholson Viola Mickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry K. Chaney / Daughter 14810 Lone Oak Road, Cresaptown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) MD Vet Cem @ Rocky Gap 12/07/2010 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, 21. Sit nature of Funeral Service Li, 404 Decatur Street, Cumberland, MD 21502 Part T. Inter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner a consequence of alor Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform death? 2 🗆 No 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 🗀 Yes 2 No ER/Outpatient 3 DOA 1 Inpatient 2 I 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year) D22181 December 3, 2010 3+ ted cause of death (Item 23a) (Type, Print) Gary L. Wagoner M.D.. 925 Bishop Walsh Road, Cumberland, MD

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

DEC

6

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DEC NELLIE INEZ OAKES 2010 9:50P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENESIS LA PLATA CENTER PLATACHARLES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min 1 □ M 2×□X1 WEST Director 224-24-1977 FEB. VIRGINIA 86 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits ms 23a or 28a-f sho must be notified at filed within 72 hours after death with the Maryland Funeral Director MD PRINCE GEORGES ACCOKEEK 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must be 2706 ACCOKEEK ROAD WEST 20607 S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 XMarried Yes 2 X X Yo Yes, Give Maryland 21215-0036 1 Yes XXNo Specify: "natural" Completed 3 Widowed 4 Divorced WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 HOMEMAKER AT HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM H. GREY CELIE ELVORY CALLAHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LELAND C. OAKES/SPOUSE 2706 ACCOKEEK RD.WEST ACCOKEEK, MD 20607 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State DECEMBER 1 Burial 2 ☐ Cremation 3 ☐ Removal from State WASH.NATIONAL CEM 27,2010 SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Signature of Funeral Service Licensee M00641 80 5635 WASHINGTON 20646 AVE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Foilure Onset and Death to thrive Physician disease or condition Medical resulting in death) Due_to (or as a consequence of) Examiner Preumonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ne Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Month 5 Other (specify) Dav Year Pregnant at time of death tor: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 2 🗆 No 1 Yes 25. Was case referre o medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗆 Yas 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death.

Funeral Director: After this 27. Man er of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Pyes 2 No Investigation Accident 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

Mu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2010 Phyllis Agnes Payne 10:35 a^M December 4, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick St. Catherine's Nursing Center Emmitsburg 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 S F 86 Dec 11, Maryland Director 219-20-0708 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location all Hygiene.
A thygiene.
A other than "natural", or Rema 23a or 28a-f show avent, the Modical Examinar must be undifficial. 10a. State 10b. County 1X Yes 2 ☐ No Emmitsburg Maryland Frederick Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21727 331 S. Seton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white δ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nursing Assistant 9 traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be and Menta Lillian Ward Frank Pryor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17200 Mountain View Road, Emmitsburg, MD 21727 f Health Sheila Mulligan, friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Depertment of H important: If its any injury or ot once. 1XBurial 2 ☐ Cremation 3 ☐ Removal from State Emmitsburg Memorial | 12/9/2010 Emmitsburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final a 8/ Physician 0 a 10 M disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the e P.O. 9 Unknown 9 Unknowh 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ⋛ page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 No Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 1 Yes 2 No certificate the Hospital or Attanding Physician: After this certification funeral director, 25. Was case referred to medical 26. Place of Death |Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ☐ ER/Outpatient 3□ DOA 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ftem, 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

10 31. Date filed (Month, Day, Year)

DEC 0 6 2010

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12 Month 5^{Day} Year 10 22:30p M Proctor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Southern Maryland Clinton George 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) WashingtonDC 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 2-10-1944 1 X M 2 | F Director 218-38-9348 66 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Brandywine <u>Marvland Prince George</u> 10g. Citizen of What Country? Funeral 15710 McKendree Rd 20613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2 🕱 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Noivorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. George Proctor Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Proctor/son 4311 Will St. Capitol Heights MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State Hertiage Cem. 12-11-2010 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of #uneral Service Licensee 22. Name and Address of Facility <u>Adams Funeral HomePa, Aquasco Md 20608</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Bleeding Physician/ yas winter tind disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Severe GAS trutos Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by acute My occardeal 1 Yes 2 No 3 Probably 4 Unknown Polycystickidney Discase 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was cast referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0055120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

Palmer

31. Date filed (Month, Day, Year)

am

32. Registrar's Signature

recen

1328 Southern avenu SE Sute 310 Washington

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rae Pryor Donna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland g. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Apr 27 1 □ M 2 □ **F** Director 217-42-7145 67 Usual Residence of Decedent show 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified WV Mineral Ridgeley 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or Funeral 26753 RR 4 Box 196 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced white Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Alleg. Board of Ed Teaching Assistant Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) 12 should be file lith and Mental H 27 is marked of r traumatic ever မ Margurite E. (Goss) Wrightsman Chaney Frank D. Wrightsman, Sr. permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ridnelev WV 26753 19a. Informant's Name/Relationship (Type, Print) husband Robert Pryor 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Sunset Memorial Park 1 X Burial 2 Cremation 3 Removal from State 12/10/2010 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility and Home, PA Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final avernoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): ending physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Box in the past 12 months?

1 Yes 2 No jo Month Day Year been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Yes မြ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? 1- Natural 5 Pending injury o 24 hours after death.

e Funeral Director: After the function of the functin 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated
3 Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of ce 29c. License number DOO 33250 Dec. 6 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE CLIMBERLAND, MID GRUPTA-M.D

Registrar

DHMH 17 Rev 7/2009

State

Registrar's Signature

9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0253 M YOGINIBEN V. PATEL Pecember 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Memorial Hospital Easton 9. Birthplace (State or Foreign Country) INDIA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8 Date of Birth **Funeral** (Month, Day, Year) 5/31/1965 Days Hours 1 □ M 2**X** F 45 Yrs. Director 152-88-2816 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No MARYLAND **TALBOT EASTON** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 8642 CHESTER COURT 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married ☐ Yes 2**X** No Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: **ASIAN** 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEKEEPING **HEALTHCARE** 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHIMANBHAI PATEL JYOTSHABEN PATEL of Health and Nitem 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yoginiben 8642 CHESTER COURT, EASTON, MD 21601 VINAYKUMAR G. PATEL / HUSBAND Baltimore, 20a Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it ☐ Burial 2X Cremation 3 ☐ Removal from State MID SHORE CREMATION CENTER BY 12/15/2010 CAMBRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) COLLEEN CURRAN-BROMWELL, P.A. permit. Signature of Funeral Service 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securitally list our ditions Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 X No Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

DHMH 17 Rev 7/2009

3 🗔

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

w. Nonte

only one) 29b. Signature and title of certifier

32. Registrar's Signature

Silve

EASTON

10-09495

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erry Robertson	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No.	ala Lagar
Physician	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day	3. Time of Death
Medical Examine	Terry Wayne Robertson December 10, 2010	0700 Hrs
		nty of Death ni ngton
Funeral		YYY) 9. Birthplace (State or Foreign WV
Director	233 88 5560 12 Months Days Hours Min. Aug 11, 19	Country)
kue	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
*	Berkeley Hedgesville	1 Yes 2 No
farylar 28a-f :		What Country?
with the Maryland ns 23a or 28a-f sho be notified at once area Director		JSA
tems 2	2 1 Never Married 2 Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	ace - American Indian, Black, Vhite, etc.
iter der in in in in in in in in in in in in in		white
ours at atural xamin	D 10 Dates	f Business/Industry
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin	Elementary/Secondary (0-12) College (1-4 or 5+)	cking
-00% d with grene.	S 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surna	ıme)
21215 lid be file Mental Hy marked or cvent, th	🖀 John William Robertson 📗 Ethel Nettie Ada	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Commission by Firnaral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Christopher Levy/son 1964 C. Security Rd. Hagersto	
and 2 leath litem 2 traum	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location	on - City or Town, State
nord	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify. Omps Crematory 12/16/10 Win	chester. VA
Baltimore, permit. Pages I ar Department of Her Important: If ite	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rosedale Fune	eral Home
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or	
Physician Medical	failure. List only one cause on each line.	Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Complication of Neck Injury Due to (or as a consequence of):	
<u>.</u>	Sequentially list conditions, b.	
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Universe Due to (or as a consequence of): Due to (or as a consequence of):	
Tred Insit	events resulting in death) Last Due to (or as a consequence of):	
50, te be executed ysician and burial - transit	© X UNPENDED	
760, icate be physic the bur		e of delivery
Box 6876(e death certificate the attending physed for use as the b	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	h Day Year
Bone deat	Yes 2 No 9 Unknown 9 Unknown	activity to to the ange of death?
P.C.	1 Yes 2 ✓ No	ontribute to the cause of death? 3 Probably 4 Unknown
ds, equire- ecen sig ould be	m i	b. Were autopsy findings available
e law re has be ge 2 sh	autopsy performed? 1 ✓ Yes 2 No	prior to completion of cause of death? 1 Yes 2 No
tal Rection: The certificate ector, page	a 25. Was case referred to medical 26. Place of Death (Check only one)	1 65 2 140
Vita	25. Was case referred to medical examiner? 1 Yes 2 No No	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be artification: To Be Completed	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury ox heavy palat 1 Natural 5 Pending 1.2.2.2.00 1 No feat 1 on subject to the subject t	e of groceries
isio Atten er death rector: by the	Pending Investigation 12–22–09 unknown 12 Yes 2 No fell on subj	mber or Rural Route Number, City
Div Bospital or 24 hours afte Funcral Dis tely filled in	Natural 2 X Accident 3 Suicide 6 Could not be determined 1 Specify) Natural 2 Natural 3 Pending Investigation 3 Suicide 6 Could not be determined 1 Specify Food Lion Grocery Store Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 5 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on subj Natural 6 Pending Investigation 1 2-22-09 unknown 1 X Yes 2 No heavy palat fell on s	
0 - 3 -	29a, Celuller	
To the within 2 To the complet	and manner stated.	signed (Month, Day, Year)
		per 11, 2010
	30. Name and address of person who completed cause of death (Item 23a)	
	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 12 31 Date filed (Month, Day, Year) 32 Rigistrar's Signature	
State Registra		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ December Austin Granvel Rinker, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington County Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day March 1 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Min. Mary Land 219-66-1655 Director 1955 Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County Funkstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 West Baltimore St. 21734 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give Year or Dates. Black, White, etc. þ 1 ☐ Never Married 2 🂢 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Research Technician Institute of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Austin G. Rinker, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic Lvndell Rinker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda J. Rinker-wife West Baltimore St. Funkstown, MD 21734 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) 12-13-2010 | Hagerstown, Maryland Rose Hill Cemeterv 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on eagh line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death emone a Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated partials) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached f 1 ☐ Yes ∠ ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ves 2 No 3 Probably 4 Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) 2 No 1 🗌 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nursus Practionar: It this basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifier 29d. Date signed (Month/Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Interian St. Hagerstown MO 21740 SH 9+1 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Rich ard Son) ark 12 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Julia Manor Washington Haberstown enter Health 8. Date of Birth (Month, Day, Year) Nov. 28, 1926 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months 1 ☑ M 2 ☐ F Hours Maryland 84 219-20-3874 Nov. Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a, State 10c. City, Town or Location Director Hagerstown 1 X Yes 2 No Washington Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21742 928 St. Clair Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give white Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) aircraft factory worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Elizabeth Patterson Harold Bateman Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 928 St. Clair St., Apt.6, Hagerstown, Md. 21742 Doris J. Poffenberger daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 12/8/2010 Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME Signature of Funeral Service Licenses Wilson Blvd., Hagerstown, Maryland 21740 Ε. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Athero Sulero tice
Due to (or as a consequence of): Ph_sician/ disease or condition Medical resulting in death) Examiner abetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months? Day Month Year 4 Pregnant
9 Unknown Pregnant at time of death Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced Vascular Dementia; Parkinsons 1 Yes 2 No 3 Probably 4 Unknown Disease; COPD; Chronic Renal Insufficiency 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: At 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Day, Year 12/6/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Elsie Mae Robeson December 05, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Goodwill Mennonite Nursing Home Garrett **Grantsville** 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Hours Days Months Director 76 220-28-9783 December 14, 1933 Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director Allegany Frostburg Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1306 Finzel Road Funeral U.S.A 21532permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any Injury or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond O'Neal Dorothy Hopkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Robeson husband Maryland 1306 Finzel Road **Frostburg** 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) December 07, 2010 Route 40 West Maryland Mount Zion Cemetery 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Inhol-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should Completed 24a. Was an autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Month

12:20 PM

Birthplace (State or Foreign Country)

10d Inside City Limits

21532-

3-4 MonTa

Day

1 □Yes 2 X No

Maryland

Black. White, etc.

White

State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

dean

0

32. Registrar's Signature

all

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours a To the Funeral D

3

nols

29c, License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 17 2010 T EDGAR NATHANIEL ROBERTS, JR. AUG 2:15 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY Social Security Number 6. Sex 1 🖾 M 2 🗆 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Belize Months Days Hours Min. Month, Day, Year Director 324-76-7634 39 1971 Jan. Usual Residence of Decedent 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director GA Liberty Hinesville 1**X** Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 21 Crosby Dr. 31313 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 X Yes 2 No 1990 Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Mes 2□No Specify: Belize If Yes. Give Black Specify: 2010 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Soldier 5 1 US Army Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ္ Edgar Nathaniel Roberts Sara Avuso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Jannett C. Roberts/Wife Hinesville, GA PO Box 2407 31310 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State emetery, crematory or other place) Arlington National 12/23/10 Arlington, VA 4 Donation 5 Other (Specify) Signature of Funeral Service Ligensee 222<u>03</u> 22. Name and Address of Facility -03 Murphy Funeral Home 4510 Wilson Blvd Arl., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ COMPLICATIONS OF BLAST INJURIES disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Due to for as a consequence of Cause (Disease or iinjury burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) detached the 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed' this certificate 2 🗌 No 1 X Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 X Yes 2 🗌 No Other: 2 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) JUN 26 2010 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 🔲 Natural 5 Pending 9:40 P 1 🔀 Yes 2 🗆 No ROUTE CLEARANCE OPERATION 2 Accident Accident Investigation 24 hours after deat Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) AFGHANISTAN BATTLEFIELD Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed 2 😾 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Religion Della

31. Date filed (Month, Day,

STABLEY

MD

MC

Registrar's Signature

USN

Knows

CDR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0101242667 (VA)

Parka

August 18, 2010

ARMED FORCES INSTITUTE OF PATHOLOGY

1413 RESEARCH BOULEVARD, ROCKVILLE MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month [™]2010 Arthur Ketchum Rutherford II Dec. 6:00 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Northampton Manor Health Care Frederick Frederick Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 5, 1929 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Hours 1 🔽 M 2 🗆 F 81 438-42-0346 Georgia Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State Maryland 10b. Count City, Town or Location Frederick filed within 72 hours after death with the Maryland 10d, Inside City Limits Directo Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8163 Stonr Ridge Drive 21702 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 1951 –1953 Year or Dates 1951 –1953 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2XXMarried δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: White 3 Divorced Completed or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working fife. DO NOT use retiged) Independent Representative 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Children's Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Winiferd Moore Arthur Ketchum Rutherford, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8163 Stone Ridge Drive, Frederick, MD 21702 Mrs. Eleanor Rutherford, wife 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Smithsburg Crematory Dec. 16, 2010 Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Keeney and Basford PA Funeral Home 21. Signature of Funeral Service Lic M00255 Fast Church St Frederick. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final set and Death Ph sician/ ESOPH4GEAL CANCER disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law performed 1 ☐ Yes 2 ☑ No 1 🗌 Yes 2 🗹 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ♠ No Hospital: Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier MD 021936 me lo on December 15, 2010

Registrar

DHMH 17 Rev 7/2009

State

JOHNSON DR

FREDERICK MD

650 THOMAS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. DONELSON MD

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edna Mae Spade 9:35ZOID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Meritus Medical Center 7. Age (In yrs. last birthday) 79 Yrs. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign Masey band **Funeral** Augronth Day, Year 931 Hours 1 M 2 XX 215-26-7026 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any rigury or other traumatic event, the Medical Examiner must be notified any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington Hancock MD 1 Yes 2XXNo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 14040 Hollow Road 21750 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2√X No Specify: ▼ Widowed 4 □ Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working . DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Garment Presser 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Snyder Edith Twigg Eugene Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 W. Brandt Boulevard, Salunga, PA 17538 Charles R. Spade - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State White cover thur chief cem. 12/16/2010 Warfordsburg, PA Donation 5 Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility Helsley-Johnson Funeral Home, Inc. M00522 25411-1855 Union St., Berkeley Springs, WV 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MYOCARDIAL INTARCTICA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 1706 t RENAL DISTAIL DND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). ATRIAL or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical HYPERTHUSION Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 🗻 g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 After this certificate has page 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? Accident Investigation the 24 hours after deal Pruneral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical 29a. Certifier 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 within 2 To the only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year, MOHAMMED A212 12/15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pus Rd. Hagerstown MO 21742 MOHammed MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

O DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 9, 2010 7:20AM **Physician** Essie Ρ. Stoker /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil Elkton Care and Rehab Center Elkton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5/4/1924 Birthplace (State or Foreign
Country) **Funeral** Hours Year 1 □ M 2 □ Days Min. 86 NC Director 192 34 1691 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be retified at 10a State Cecil Elkton 1 X Yes 2 □ No Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 USA One Frice Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify þ Specify: 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Ital Once. 8 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lilly Eldreth Frank Phillips ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 453 Elkton, MD 21921 Judy Lindsey 20b. Place of Disposition (Name of Christ Commun. 117) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/13/2010 West Grove, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Edward L. Collins Funeral usa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIABETIS **Physician** UNCONTROLLED disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL Exquerniany flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ADMIL STENOSI and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 Tyes page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No has autopsy performed? Yes 2 No certificate 1 □ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0065733

State Registrar IN A E- Ingit street

21921

ELKINA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NARAYANA 31. Date filed (Month, Day, Year) V. PULA

32. Registrar's Signature

Brising

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 1 James F. Scherr 201[°]0° 1:30 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 13, 1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 X M 2 🗆 Months Hours 67 New York Director 089-36-1258 Aug Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Taneytown Carroll Maryland 1 Yes 2 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 203 Butterfly Drive USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Defense Industry Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Janice Schwantz Francis Otto Scherr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
203 Butterfly Drive, Taneytown, MD 21787 Barbara A. Scherr, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/07/2010 Westminster, MD Meadow Branch Cem 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 w Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition must Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Uncerlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed bunial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the bunal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t 1 🔼 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 912 S. SiKorski MD Wash. Rd. Westminster

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

DEC 06

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1250 PM SmI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Randallstown Seasons Hospice 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Md. 1 **X**M 2 □ F Hours 01197571927 83 Director 217-20-3860 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Md. Carroll Eldersburg 1 Tes 2 No 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral USA 21784 6414 Locust Lane items within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō þ 1 Never Married 2 Married ☐ Yes 2 **X** No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Carry out Seafood Owner Tangier Seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Melvin Smith Josephine Dietrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Joan G. Smith(Wife) 6414 Locust Lane Eldersburg, Md. 21784. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/07/2010 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funer is ervice 22. Name and Address of Facility Haight Funeral Home & Chapel PA Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE use yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No g Unknown Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à To the Hospital or Attending Physician: The law requires th within 24 hours after death.

To the Funeral Director: After this certificate has been signs completed filled in by the funeral director, page 2 should be Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perfor 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မ ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier WJL eted cause of death (Item 23a) (Type, Prin 30. Name and address

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 2010 04:40 PM SARAH MARIE STANLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL CHARLESTOWN 208 MARKET STREET If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth HAVE THE PROPERTY OF THE PROPE 5. Social Security Number **Funeral** Days Hours 1 □ M 2X F JULY 5, 1951 59 Director 213-60-7363 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No CHARLESTOWN MARYLAND CECIL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral UNITED STATES 21914 208 MARKET STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X ANo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black White, etc. 1 Never Married 2 X Married Completed by Specify: WHITE 21215-0036 1 Yes 2 XNo Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CATHERINE I. HARTZELL ROGER H. CALVERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 208 MARKET STREET, CHARLESTOWN, MARYLAND 21914 DON E. STANLEY / SPOUSE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State DECEMBER. 1 Burial Cremation 3 Removal from State 8, 2010 NEWARK, DELAWARE MAYERDALE CREMATORY 4 Donation (Specify) 21. Signatur of tu 22, Name and Address of Facility CROUCH FUNERAL HOME al Ser STREET, NORTHEAST, MARYLAND21901 127 SOUTH MAIN Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a nonsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral injector, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death g Unknown ins certificate has been signed by director, page 2 should be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 201 Month Robert John SEEK 1:56 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 17530 W. Washington Street 8. Date of Birth (Month, Day, Yea Hagerstown 5. Social Security Number 6. Sex 1 M ≥ □ If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours **Director** 86 196-16-2885 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 17530 W. Washington Street 21740 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Year or Dates. 1943-46 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Minister Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Seek Eva Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy R. Seek - Son 9622 Gashouse Pike, Frederick, Maryland 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Park 12/11/10 awn Mem. Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Me Physician, ta static disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Secure tially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transi Cause (Disease or iinjury Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Year Voc 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should been s New 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 XNo ၉ After this 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) . Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pendina work? 24 hours after death. Funeral Director, A 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur of certifie 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Normern

30C

32. Registrar's Signature

Mahmesd

Itve.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 10:15 AM 2010 Mary Genevie SPRANKLE /Medical Eacility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington ta gerstour VIIIage If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🗓 F 101 **Director** 214-09-5443 Aug. 23 1909 Pennsylvania Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director N Yes 2 No Maryland Washington <u>Hagerstown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 by Funeral 1183 Luther Drive filed within 72 hours after death 21740 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 1 ∏Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No White Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. College (1-4or 5+) 10 0 Piece work Shoe Factory 7 is marked other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ George Mosser Florence Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) per it. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tran Barbara Adams - Daughter 309 S. Church St. Middletown, Maryland 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 12/11/10 Hagerstown, Maryland 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** alzhuenn 342000 disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner 15 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed thus after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☑ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4₺ Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 24 hours a PSI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D28365 12-9-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Strul- Hagerston 17D 2 1740

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 12 Marian Margaret Scott /Medical 2010 4:26 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12812 Pintail Drive Ocean City Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2X F Director 213-20-4591 85 9/8/1925 Indiana Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12812 Pintail DRive 21842 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes A☐ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst Federa1 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 is marked otl Clarence Henry Morley Hilda Ethel Greenback 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S John Tanner Scott/husband 12812 Pintail Dr Ocean City Md 21842 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Garde 12/9/2010 Bel Air MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 108 William St Berlin MD Burbage Funeral Home 21811 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MOTASTANO Physician Dicensi ARCINONA resulting in death) /Medical Due to (or as a consequence of): Examiner y penteusici if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine TY PERUIPIDEMENT attending physician and I for use as the burial-trai Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2□No be detached the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 XNo 3 Probably 4 □Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1∐ Yes 2**/**2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only or Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending 24 hours after death.
Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 114 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DI 10

State Registrar

31. Date filed (Month, Day,

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Smith Earl James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western MD Regional Medical Center mbertan If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
05/21/193 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗖 M 2 🗆 F 78 **Director** 189-30-2849 Pennsylvania Usual Residence of Decedent 28a-f shov 10b. County 10a. State an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director PA Bedford Artemas 1 🗌 Yes 2 🛣 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1503 Clear Ridge Road 17211 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in 0.5.
Armed Forces?
1 ☑ Yes 2 ☐ No 1953—
If Yes, Give
Year or Dates. 1961 Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 1961 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Warehouse Manager Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Earl W. Smith Nellie Robinson or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Wanda L. Smith / Wife 1503 Clear Ridge Road, Artemas, PA 17211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fairview Cemetery 12/04/2010 Donation 5 Other (Specify) Artemas, PA e of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, 21. Signatu 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2 DA 4/S Non Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Examir death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for Month Day Year been signed by the should be detached 9 Unknown Part II. **Other significant opnditions c**ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 **W**60 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 W Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Um Mi Wullan 20+

Registrar

State

Box 68760

P.0.

Records,

Division of Vital

12501 Willowbrook Road, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.,

32. Registrar's Signature

William Lamm,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 27PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death University of Maryland Medical Center altimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 2, 1950 Birthplace (State or Foreign Country)
 MD Funeral 1 XM 2 - F Months Hours Min Yrs Director 222-32-4975 60 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director DE Sussex Dover 1X Yes 2 ☐ No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 31 S. Kirkwood Drive 19904 USA death v 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, med Forces' Black, White, etc.
African þ 1 Never Married 2 Married 1 XYes 2 No Army Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 Divorced American Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than within 7 Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N 12 Laborer Poultry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Davis, Sr. Lillie Emily Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel Grooms/sister 31 S. Kirkwood St., Dover, DE 19904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Crematory of Delmarva 12/2/2010 Delmar, DE 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 ardi disease or condition Medical resulting in death) Due to (or s a consequence of): Examiner Sequentially list conditions ner if any leading to immediate. Enter Underlying Cause (Disease or linjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been been accounted to the Funeral Director. Exam burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No **Director:** After this certific d in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other Certificate: To 1 Tyes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work?
1 Yes 2 No 5 Pending Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa nd title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 010 Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Baltmore S. amontha 31. Date filed (Month Day, 32 Registrar's Signatur State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Plea	se Type or Pri									egible).		
		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1 1 1 1 1 1 1 1 1 1											LOLIS)		
		1. Decedent's Name (First, Middle, Last) 2. Date of Death										UIL	,	3. Time of Death	$\widehat{}$	
Physicia	- A			Florence	e Sn	yder					Month December	Day	2010		1:02 A.	М
/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death								of Death			ounty of D	eath		
		Go1den	0					.,	stown				Washi			
Funeral Director		5. Social Security N 201–16–1		6. Sex 7. A	ge (In yrs. 88	last birthday, Yrs.	Months 1	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Dec • 10	rth ay, Year) 9. Birthplace (State or Foreign Country) I owa				gn
and w		Usual Residence of 10a. State	f Decedent 10b. County		10c. Cit	y, Town or L	ocation							10	d, Inside City Limit	ts
/arylk	ō	MD.	1	ngton		Hagers									1 X]Yes 2 □ N	10
the last the	Director	10e. Street and Nu		8-			10f. Zip (Code				10g. Citize	Citizen of What Country?			
with 13a ol	0	750	Dual H			2	1740)			U.S.A.					
deat	Funeral	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U	.S. 13.	. Was Decede	ent of H	lispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	. 14	I. Race - A Black, W			
72 hours after death with the Marylan 72 hours after death with the Marylan "natural", or items 28a or 28a-f show dical Examiner must be notified at	by		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ № If Yes, Give Year or Dates:				1 ☐ Yes 2				· · · · · · · · · · · · · · · · · · ·			Wh		
72 hornaturalical E	ted	(Sner	15. Deceder	nt's Education est grade completed)		16a. Dece	edent's Usual	Occup	ation	t of work	ina	16b. Kind	of Busine	ss/Ind	ustry	
If it is within 72 hours after death with the Maryland flied within 72 hours after death with the Maryland there than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5					e kind of work DO NOT use Seamst			. 01 11 011	9	Garment Mfg.			Mfg.	
e filec al Hyg othe vent,	Be C	17. Father's Name		,					18. Mothe		e (First, Middle,		urname)			
Ment Ment arked atic e	70		Fran	ık Randall							lia Gre					
permit. Pages 1 and 2 should be filed within 72 ho peparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		19a. Informant's Name/Relationship (Type. Print) Cindy Pittman/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or To														
ages 1 g int of He t: If item / or othe		cemetery, crematory or other place)								-City or Town, State castle, PA.						
nit. P artme ortan Injur		21. Signature of Fu							- !		'uneral Home Inc. Greencastle, PA. 17225					
Dep Dep Conc		H. Me	artin Z	emmer o	<u> </u>	2	Zimmern 45 S. (nan Carl	And S lisle	St.	Funeral Greenca	Home astle	, PA	. 17	7225	
E - 27		23a. Part1. Enter t	the disease, o	r complications that cause t only one cause on each	ed the deat										Approximate Interval Between	
Physician		Immediate Cause	(Final	· Olm	ma	nı.	Arter	u	de	C	ne				Onset and Death	
/Medical		resulting in death)		Due to (or a	s a conseq	luence of):		1			4				1110	
Examiner		Sequentially list co	onditions,	b ell	a. Our any Artery distance mins Due to (or as a consequence of): b. Chebro vas cular a ecident 64 cons Due to (or as a consequence of):											
ed	nine	if any, leading to in cause. Enter Unde Cause (Disease or	mmediate erlying r iniury	Due to (or a	s a conseq	quence or):										
e executed lian and urial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):												_		
e be e	_ 1			C _d												
g phy g phy as the	edic			- d.			-									
death certificate be attending physicial for use as the bur	M/ne	200. Was decedent programmy							3d. Date of delivery							
The law requires that the death certificate be ate has been signed by the attending physician page 2 should be detached for use as the bur	Physician/Medica	in the past 12 months? 1								Month Day Year						
that the de	Phy			ions contributing to death	but not res	sulting in the	underlying ca	use aiv	en in Part I		23e. Did t	obacco us	e contribut	te to th	ne cause of death?	
w requires to been signed should be	d by										1 🗆 '	Yes 2□	2 No 3 Probably 4 Unknown			wn
w req	Completed			-		-					24a. Was	an	24b, Wer	e auto	psy findings availat	ble
The lav e has age 2	duic											rmed?	prior deat 1 □	th?	npletion of cause o 2∖D∕No	ıf
sician: The la certificate ha irector, page 8	a)	25. Was case refe	rred to medica	al					26. Place	e of Dea	1 Yes th (Check only o	2√2No nne)		165	20140	
nysici lis cer direct	o B	examiner? 1 ☐ Yes 2√	No	Hospital: 1 ☐ Inpa	tient 2] ER/Outpatie	ent 3 □ DO	A Oth	ner: Ni	ırsing H	ome 5□Resi	☐ Residence 6 ☐ Other (Specify)				
ਲ ਵੇ ਨੇ (n: T	27. Manner of Dear	ith 5 □ Pendi	28a. Date of In (Month, E		28b. Time Injury	of 28	Bc. Injui Wor				how injury occurred				
tendingsath.	atic	2 Accident	invest	igation			M		Yes 2	No						
al or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (St. City or Town							Street and wn, State)	Number o	r Rura	l Route Number,				
To the Hospital or Attending Is within 24 hours after death or To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)		ng Physician: To the best Examiner: On the basis and manner:	of examina											
To the within Fo the comple	Me	29b. Signature and	d title of certific				29c.	Licens	se number				_		Day, Year)	
F > F™ 0		Ma	Men	of surget	$\overline{}$		12	2	836	5		12	- 14-	10		
		30. Name and add	fress of persor	who completed cause of	death (Iter	m 23a) (Type					1					
		31. Date filed (Mor	N 2 A	2 DSHAP	trar's Sign	368 ature	null	2	tree	1- (tergs	Kerre	1-4	07	1740	-
Sta Registr			DEC 2	1 2010 Day	ساس	A. A	arkel									

OHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 William Trollinger. Jasper 02:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert 4559 Sixes Road Prince Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🕅 M 2 🗆 F 10/05/1952 Washington, DC Director 213-54-5215 58 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🖾 No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 45357 Clarkes Landing Road 20636 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: If Yes Give Specify: White "natural" 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the HVAC Service Technician DC Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 William Jasper Trollinger, III Peggy Maddox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 7317 Hollow Brook Court, Ft. Mill, South Carolina 29707 Lacey Trollinger / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 12/11/2010 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the diseas 4, or complications that caused the d. 4h. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate al Between Immediate Cause (Final -Physician/ disease or condition Medical resulting in death) **Examiner** a cono Corcinima Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician ned for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month ate has been signed by the page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform I or Attending Physician: The after death.

Director: After this certificate b 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital c 24 hours at Funeral D Medical Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Checl Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only a 29b. Signatu 29d. Date signed (Month, Day, Year) Dec. 07, 2010 ress of person who completed cause of death (Item 23a) (Type, Print) MECHANICS in Cle More, lun 31. Date filed (Month, Day, Year) 32. Registra State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert N. Truly Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Allegany Western Maryland Medical Center Frostburg 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 214-28-6278 81 September 01, 1929 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ohen any injury or other traumatin author. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 127 Washington Street 10f. Zip Code 10g. Citizen of What Country? Funeral 21532-U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Korsan 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) O^{College (1-4 or 5+)} Elementary/Seconday (0-12) Powder Operator Govt. Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frank Truly Elizabeth Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Davis Daughter 404 Grandview Drive Maryland 21532-Frostburg 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory Cumberland Maryland December 02, 201 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 / hola 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VASCULAR GEREBRO disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 2 No signed by the a 9 Unknown Part II. **Other significant conditio**ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performed? certificate 1 ☐ Yes 2 ☐ No 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No 1 Donpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier DECEMBER 02 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) MLS

State Registrar

DEC 0 2 20

32. Registrar's Signature

21507

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 10 Physician/ 8:56 AM ma Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 95 West Oldtown Road Apt. 5B Cumberland Allegany Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth **Funeral** Months Min 2163 Director Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the May/and Department of Health and Mental Hyglene. Important: If first 71 is marked other than "naction" any injury or other terms. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ✓ Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 95 West Oldtown Rd. Apt. 5B 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: white 3 Widowed 4 ☐ Divorced Specify. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Lou (Cayton) Myers Franklin L. Myers 19a. Informant's Name/Relationship (Type, Print)
Daniel Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1720 LVY St. # 141 Waynesboro VA 22980 Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Temation 3 Removal from State Scarpelli Funeral Home, P.A. 11/30/2010 Cresaptown MD 4 Denation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Full Veral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner TN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagn 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? 10 2 🗹 No Other: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: The best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Pyantiy (in f) the best of my knowledge, death occurred at the fine date and place, and due to the cause(s) and manner stated. (Check 29b, Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year) 30

State Registrar 30. Name and address of person who completed

31. Date filed (Month,

(Item 23a) (Type, Print)

Registrar's Signature

10-09459 Wilson Blackfood \	1		or Print in Bla e of Maryland /	Depa		Hea	alth an			giene		1)	The second secon
Physician Medical Examine	1	1. Decedent's Name (First, Middle, L Wilson Blackfor								Date of Deat Month December		ar	3. Time of Death 0700 hrs
Medical Examine		4a. Facility Name (if not institution,	b. City	, Town, or	Location o		December	9, 2010 4c. County	of Deat				
		Washington County Hos		gerstowr				Washin					
Funeral Director		222 06 1504	Sex 7. Age	(In yrs. 1 95	last birthday) Yrs.	If Ur Mor	nder 1 Yea	_	1.0		h(MM/DD/YYY 20,1915	Foreig	rthplace (State or gn i'rryinia
any	-	Usual Residence of Decedent 10a. State 10b. County	11	Oc City	. Town or Location	20							10d. Inside City Limits
≥	١	Maryland Washin	1	,	lliamsp								1 Yes 2 No
the Maryland a or 28a-f show tified at once. Director		10e. Street and Number 16505 Virginia	Ave.				Zip Code 21795	5		10	0g. Citizen of W		intry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		1. Marital Status 1 Never Married 2 X Marri	12. Was Decedent E	ver in U		Dece	dent of His			ify Yes or No- can, etc.)	14. Rac		ican Indian, Black,
s after de iral", or niner m	-	3 Widowed 4 Divorce	ed If Yes, Give Year or Dates:	41° 947	1	Yes	2 X No	specify:			Specify:	Whi	te
nours.		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade comp College (1-4 or 5-		16a. Decedent during mo	s Usua	al Occupat orking life	tion (Give I DO NOT	kind of wor use retired	k done I)	16b. Kind of B	usiness/	Industry
5-0036 ed within 72 hour stygiene. other than "natu the Medical Exan Completed			4	,	Spec:	ial	Ager	nt			Federa	1 G	overnment
Saltimore, MD 21215-0036 eermit. Pages I and 2 should be filed within 7 bepartment of Health and Mental Hygiene. mportant: If item 27 is marked other than njury or other traumatic event, the Medical		7. Father's Name (First, Middle, La William Wade Wad	,						,	irst, Middle, M lackfo:	laiden Surname))	
b 21 should I and Mer 7 is mar	2 1	9a. Informant's Name/Relationship Dorothy Waddy-wi		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cool 16505 Virginia Ave. Williamsport, MD 21795									
e, M l and 2 Health item 2'	- 1	20a. Method of Disposition			Place of Disposi	ion (N	ame of cer			TTTAMS Date	20c. Location	D ZJ	Town, State
Pages nent of nent of rent: If		1 Burial 2 X Cremation 4 Donation 5 Other Spec		Sm:	crematory or oth ithsburg	3 C1	remat	ory	12-1	0-2010	Smiths	burg	g, Maryland
Balti permit. Departn Import	2	1. Signature of Funeral Service Lic	ensee	+	22. Na	ame ar	nd Address	s of Facility	Doug	las A.	Fiery Hagerst	Fune	eral Home
Physician	2	3a. Part I. Enter the disease/or confailure. List only one cause on		e death									Approximate Interval Between Onset and
Examiner		-	a. Blunt Force Head										Death
			b.	uerice o									
ed Insit Examiner	i	f any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated	Due to (or as a conseq	uence o	f):								
uted nd ransit		events resulting in death) Last	Due to (or as a conseq d.	uence o	f):								
be executed dician and urial - transi		UNPENDED	AMENDED										
1876(rtificate ing phy.	11 23	F FEMALE: Bb. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	of pregi		ıl deati	h 3[Ectopic	pregnancy	,	23d. Date of Month		y Day Year
D. Box 68760, the death certificate be executly the attending physician and check for use as the burial - transport of the attending physician and physician/Medical		Yes 2 No 9 Unknow	4 Pregnant at tir	ne of de	ath 5 Oth	er (Sp	ecify)			-			
P.O. Es that the canada by the detached by the by the by the by the by Physical By Physica		art II. Other significant condition	s contributing to death t	out not re	esulting in the ur	derlyir	ng cause g	given in Par	rt I.				the cause of death?
ds, Faquires in seen sign build be a										24a. Was a			oably 4 Unknown
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate by its after death. *I Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the bur prification: To Be Completed by Physician/Mer						_				autops perforr 1 Yes 2	ned?	prior to death?	completion of cause of es 2 No
itian: certifii rector, 1		Was case referred to medical examiner?	Hospital:					of Death (
of Vision Physics Physics Properties of Physics Physic	۱	1 Yes 2 No 7. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury		ER/Outpatient 28b. Time of In			ry at Work?	Nursing F		Residence 6 ow injury occur		
ion c tending eath. tor: Af the fun		1 Natural 5 Pending 2 ✓ Accident Investiga	Dec 9, 2010	r)	0200 hrs			res 2	S.	bject fell			
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Exhadical Certification:		3 Suicide 6 Could no determin	ot be 28e. Place of Injur	-		, factor	ry, office b	uilding, etc		or Town, Sta			amsport, Md.
To the Hospi within 24 hou To the Funct completely fil		9a. Certifier 1 Certifying Phys	ician: To the best of my ler: On the basis of exami	nowledo	ge, death occurre			-	ce, and du	e to the cause	(s) and manner	as state	ed.
To To To Com	2	9b. Signature and title of certifier	and manner stated				9c. License				29d. Date sign		

Registrar DHMH 17 Rev 1/2001 OCME 2006

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Russell Alexander MD.

State 31. Date filed (Month, 'Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

December 10, 2010

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Barbara B. Walter DECEMBER 5, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Reeders Memorial Home Boonsboro Washington County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 29,1915 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 💢 F Days Hours 203-07-9042 95 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Madical Examiner must be notified at Director 1X Yes 2 □ No Maryland Washington County Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 items 23a 141 S. Main St. 21713 U.S.A. death 1 Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No "natural", or 1 ∐Yes 2 🛣 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, I is was any injury or other traumatic event, I is was Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles H. Bechtel Mary Buch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary W. Foor-daughter 11731 Meadowlark Ave. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-9-2010 | Lititz, PA Moravian 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ADVANCED TERMINAL Y Emy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEARS CARDINE Samulation, list could be any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed 4 EMU MASS KENAL and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be o Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performe 1 ☐ Yes 2 🗷 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4₺ Nursing Home 5 Residence 6 Other (Specify) After this the funeral 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ghazala Qadir 20311 Lappans Road Boonsboro, MD 21713 301-432-8470 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8&31 Per FH &dvr G910 12/21/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2104 Medical Facility Name (if not institution, give sta City, Town, or Location of Deat 4c. County of Death **Examiner** (RV 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. ^{Year}1943 Country) 215-42-8796 MD **Director** Usual Residence of Decedent or 28a-f show notified at 10c. City permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. 10b. County 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No 10f. Zip 10g. Citizen of What Country? USF Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 11. Marital Status 14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NSTYUCTION Highway Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Charles H. Walker Alverta M. Giggerd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris M. Walker/Wife 3121 MD 21102 Main St., Manchester, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Date 20. cematery, crematory or other place)
Christ Evan.
Lutheran Cemetery 1X Burial 2 Cremation 3 Removal from State Trenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service License 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. St., Second New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the whath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the Innerial director, page 2 should be detached for use as the burial-transit sted filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 A No 2 🗌 No 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ER/Outpatient 3 DOA 1 Inpatient 2 L 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accider
3 Suicide 5 Pending work' 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completed filled Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [] 3 [] Medical paraminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year, ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name an MEMORIAL WESTMINSTER. 2115 AVE MD 31. Date filed (Month Day, Year, State Registray's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per med cert G910 12/21/10 dk

State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month December Dorothy Almeta Williams 6:49PM SOID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 5. Social Security Number 8. Date of Birth (Month, Day, Oct. 29 Funeral 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours 1 🗆 M 2 🕎 F Mary land 92 1918 214-09-8440 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington Hagerstown 1 Yes 2 X No Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 1215 Peppercorn Dr. U.S.A 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 Wo Black, White, etc. 1 Never Married 2 Married 2 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify 3 ₩ Widowed 4 ☐ Divorced White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva A. Bender John Knode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1215 Peppercorn Dr. Hagerstown, Md. 21740 Donna M. Schlotterbeck (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Dec. 18, View Cemetery 4 Donation 5 Other (Specify) Sharpsburg,Md. 2010 permit. Signature of Funeral Service Licenses any in 22. Name and Address of Facility 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician. TNOTIC Encoptaco PATH disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner umon Sequentially list conditions, if any leading to impose to cause. Enter Underlying Cause (Disease or linjury Examiner ESPIRATORY and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be URINIMA TRACT INFEETTOR Box 68760 as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death g Unknown g Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown CANDIAC ARREST peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ၉ 1 Nation 2 ER/Outpatient 3 DOA within 24 hours after death

To the Funeral Director; After thi
completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10062006 10/20/10 Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BU10 Si E AND E DAM HACI54TOWN WIREDW 31 Date filed (Month 32. Rec istrar's Signature State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician /Medical 3:35 PM 7abri Dano December 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number MA 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) / 2 - / 2 - 20 (() Birthplace (State or Foreign Country) Age (In yrs, last birthday) **Funeral** Min **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location or 28a-f shov notified at Director 1 ☑ Yes 2 ☐ No MIna 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Apt r than "natural", or items 23a or the Medical Examiner must be n 21218 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify è Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry na Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 Cremation 3 Removal from State Kallstown MD 4 Donation 5 ☐ Other (Specify) 18-2010 21. Signature of Funeral Service Licenses East Avenue 21202 mson 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only/one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Immediate Cause (Final Pulmonary **Physician** hypoplasia disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No Yes 2 No 1 Yes Physician: 25. Was case referred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) ည 28a. Date of Injury 27. Manuer of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred al or Attending P s after death. I Director; After t 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral D the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000

DHMH 17 Rev 1/2001

State Registrar 600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last), 2. Date of Death Day Year Physician Horamson ecembe nol 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mursing Monta If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1X M 2□ F Hours Director 577-46-0759 Aug.4, 1933 Washington D.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinat must be motified at Director XXYes 2 □ No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1235 Potomac Valley Rd. Funeral 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc 1XXes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2XXNo Specify ģ White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than "other traumatic event, Inc. Me. Elementary/Secondary (0-12) College (1-4or 5+) Dental Technician Dentistry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Abramson Sara Abramson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Margie Warner / Daughter 22405 Goshen School Rd., Gaithersburg, MD 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any Injury or o 5 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 12/20/2010 Beltsville, MD ^{22. Name and Address of Facility}
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD MO0382 23a. Part1. Erfler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20910 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (as a co sequence of) Examiner Sequentially list conditions, if any, leading to infine flate cause. Enter Underlying Cause (Disease or injury Examiner TLI and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed' 2. No 2 10 No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) Manney of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Baltimore, Maryland 21215-0036

death.

Hospital or Attending Physician: The law requires that the death certificate be executed after death Director: filled in by

Division of Vital Records, P.O. Box 68760, 24 hours a within 2

> State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 6.30 PM 14 12 2010 BROOKS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6050 Hordford Baltimo enesis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 □ M 2 🔽 8-42-5863 88 Director Alabama Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must he provided once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1y Yes 2 No Directo N/A MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 517 Wyeth Street 21230 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th Grade Domestic N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Turner Sarah May ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ruby Dawson(daughter) 517 Wyeth St., Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery crematory or other place).

Joseph Brown F/H
AND Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐Removal from State 12/15/10 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ²²Josephdreff. Fighrown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician auanilo disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Se uentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-trai Division or Vital Records, P.O. Box 68760, attending physician and for use as the burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Tyes 2 VIVo the 9 ☐ Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 100 page 2 certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Hospital: Other: 4 Unursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? After t (Month, Day Year) or Attending 1\□Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a To the Hospital

3

Registrar

State

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0070076

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar		-	epartment of l Certificate of l		nd Mental I	Hygien Reg. ۱	2010	40425
Physiciar Medica	al .	1. Decedent's Name (First, Middle, La. George M. Baier					2. Date o Month Dece	[Day Year 19,2010	3. Time of Death 5:55P M
Examine	er	4a. Facility Name <i>(if not institution, give</i> 701 Mustang Co			4b. City, Town, c Be1A		Death	4	4c. County of Dear Harf	
Funeral Director		5. Social Security Number 6. Social Security Number 212-20-5555 Usual Residence of Decedent	X M 2 D F	(In yrs. last birtho 86	day) If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date o Min. (Month May	Birth , <i>Day, Year</i> 2 7 . 19	g. Bir Co 24 Mar	thplace (State or Foreign untry) yland
Maryland 28a-f show notified at	irector	10a. State 10b. County Md. Ha	rford	10c. City, Town	BelAir					10d. Inside City Limits 1 Yes 2 No
s 23a or	eral [10e. Street and Number 701 Mustang Con	urt			014			Citizen of What Co	ountry?
P 7 2 2	þ	11. Marital Status 1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 A Yes 2 No If Yes, Give Year or Dates.	0	13. Was Decedent of I If Yes, specify Cub 1 Yes 2 X No	an, Mexican, F Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", only injury or other traumatic event, the Medical Examples.	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12) 8th			Decedent's Usual Occup Give kind of work done ife. DO NOT use retired, ationary E	during most o	_	1.11	Kind of Business	
/land 2 d be filed w Mental Hyg arked othe	as l	17. Father's Name (First, Middle, Last) George M. Baier				18. Mother's	s Name (First, Mic	dle, Maide	· · · · · · · · · · · · · · · · · · ·	
Mary nd 2 should salth and N 27 is me er trauma		19a. Informant's Name/Relationship (1	Type, Print) Spou		Mailing Address (Street					
imore Page 1 ar nent of He ant: If iter		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		20b. Place of I cemetery Bayvie	Disposition (Name of crematory or other pla		Date 2-22-201		Location - City or alto. Md	
Balti permit. Departri Imports any injt		21. Signature of Funeral Service Licen Buen G U	celly		22. Name and Addre	ss of Facility of Phail F	chimunek Road Be	Fune lAir,	ral Home Md. 210	14
Pnysician Medical Examiner	10	23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the cause on each line. Due to (or as a company)	e Co	encer	ng, such as ca	ardiac or respirato	y arrest,		Approximate Interval Between Onset and Death
ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a c	consequence of						
760 sate be executed physician and the burial-transit	edical	resulting in death, East	d							
	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√□ No g □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal death	3	су			23d. Date of de Month	livery Day Year
IS, P.O. uires that the signed by ald be detacted.	ן בַּ	Part II. Other significant conductors contributing to death but not resulting in the discerning waste given in Fart.							L.	o the cause of death?
Vital Record	Completed						— I ;	Vas an autopsy performed ves 2	prior to death?	ntopsy findings available completion of cause of
cian:	Be (25. Was case referred to medical examiner?	Heavital				(Check only one)			
Physic all dire	욛	1 ☐ Yes 2 ☒ No 27. Manner of Death			oatient 3 DOA Oth	4 L Nurs			6 Other (Spec	cify)
Division of V To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be	20	<i>Year)</i> inj	ury wor M 1 🗆	ryat k? Yes 2 □ N	lo		ury occurred	
Divis		4 Homicide determined determined building, etc. (Specify) 286. Location (Street, factory, office City or Town, S							ite)	
the Hosp hin 24 ho the Fune	Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	rsician: To the best of mainer: On the basis of exa se Practioner: To the basis	mination and/or	investigation, in my opin dge, death occurred at the	on, death occu ne time, date a	urred at the time, d	ate and pla to the caus	ce, and due to the e(s) and manner as	cause(s) and manner stated, stated.
o o o o o o o o o o o o o o o o o o o		29b. Signature and title of certifier	- 1-		29c. Licens		in C	29d. I	Date signed (Mont	n, Day, Year)
		30. Name and address of person who		ath (Item 23a) (Ty	/pe, Print)	258		- ()	2-21	-2010
State Registra	-	Ank Lewis Villar 31. Date filed (Month, Day, Year)	32. Registrar's	1 1-1	N. Charl	co 8,5	Ac 4100	5, B-	romotele	e, MD 21204
DHMH 17 Rev 7/200		UEU & X	LUIU MAGO	100	. 44					
				OR	IGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day , 2010 Physician/ December 11:50P Ethel H. Bolton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner woodlands Assisted Living Balto. Social Security Number If Under 1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Year Funeral 1 □ M 2 🛚 F Months Hours North Carolina Director 413-52-0882 75 Usual Residence of Deceden show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No Md Balto. Essex 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21220 13012 Eastern Avenue ıral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify "natural", 3 Widowed 4 Divorced nd Mental Hygiene. s marked other than "natura umatic event, the Medical E. Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Assembly Worker Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ر and 2 sho. • of Health and N. • em 27 is marke. • r traumatic ev. ည Francis Hill Ebb Harrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13012 Eastern Avenue Essex, Md. 21220 Jack Bolton Spouse : If item 2 or other t Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 g Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12-23-2010 Highview Fallston, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner thrive Sequentially list conditions Examine if any leading to immedicause. Enter Underlying -transit previoue due to dysphape To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? Yes 2 No death? 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မြ 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No e Hospital Carlo 24 hours after death.
The Funeral Director, Aft 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 7/2009

State Registrar

within 2.

29b. Signatyre and title of certifie

31. Date filed (Month, Day,

NELIA E. SANCHEZ-CRESPO

404 EAS TERM

address of person who completed duse of death (Item 23a) (Type, Print)

. Registrar's Signature

MD0067697

29d. Date signed (Month, Day, Year)

12-21-10

BSEX MD 21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SESMASIL 20 ZOLU EUFLYN R. 11:05A M SIAKE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Futurecare Cherry Wood Baltimore Reisterstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth Sept 28, 1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 ☐ M 2 💢 F Hours 86 Yrs. Director 217-12-8430 Pennsylvania Usual Residence of Decedent or 28a-f shov 10b County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Owings Mills Marvland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should -e filed within 72 hours after death with t Department of Health and Me-ntal Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event the Funeral 21117 USA 305 Gwynnbrook Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: specify: White If Yes, Give 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Ambrose McCauley Ruth Remitta Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa L. Heathcote, Daughter 305 Gwynnbrook Avenue Owings Mills, Maryland 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/21/10 Baltimore, Maryland Thomas Gregor 21. Signature of Funeral Service Licensee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 homas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one can be on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 🗹 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signature and title of certifier R088852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's Signatu

PUSNUE #203

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10:20P M Physician/ December Rhoda W. Burwell Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard Ellicott City Abundant Life 9. Birthplace (State or Foreign Country)
Connecticut If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday, Feb 26, 1943 **Funeral** 1 M 2 X F 67 049-32-7416 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at with the Maryland 1 ☐ Yes 2 🕅 No Director Ellicott City Howard Maryland 10g. Citizen of What Country? 10e. Street and Number ō **USA** Completed by Funeral 21042 23a 9950 Oak Lea Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, items 2 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Specify: Black 1 Never Married 2 Married ō 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 XDivorced "natural", Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Non Profit Manager 18. Mother's Name (First, Middle, Maiden Surname) Be traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Claudine Ashley ဂ James Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4013 Blackmoor Street Mount Pleasant, Seturah Walker Foxx, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 X Cremation 3 Removal from State Baltimore, Maryland 12/21/10 Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) R Name and Address of Facility to Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lerolu Alberose Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical **Examiner** Advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death IF FEMALE: 3 C Ectopic pregnancy 23b. Was decedent pregnant Year Month Day in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical Be B Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes ၉ 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: injury 5 Pending 1 🗌 Yes 2 🗌 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 4 Homicide determined

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but

4 L Homicide	determined	building, etc. (Specity)	0			
Ja. Certifier 1	Certifying Physici	an: To the best of my knowledge, death occurr r: On the basis of examination and/or investigation	ed at the time, date and place, a	and due to the cau	use(s) and manner as stated.	d manner state
(Check 2 only one) 3	☐ Medical Examine ☐ Certifying Nurse I	r: On the basis of examination and/or investigation Practioner: To the best of my knowledge, death	occurred at the time, date and pla	ace, and due to the	e cause(s) and manner as stated. 29d. Date signed (Month, Day, Year	
b. Signature and	()	Jm	29c. License number D 3 0 6 4 1			2010

Mad

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramesh Sabapathi 201-19 Packet Well Mickle 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1641 Mary Ε. Burk 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** teninsula Regional Medical Cente alisbur Nicomica 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yes 6 1940 Days Maryland 1 □ M 2 😿 F Director 216-36-9836 Usual Residence of Decedent 28a-f shov 10a. State 10b, County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified 1 Yes 2 XNo MD Wicomico Quantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5752 Sandy Hill Road 21856 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henry Johnson Rita 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Hazy Court Jacqueline A. Kane, daughter Middle River, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/21/10 Baltimore, MD 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Cremation Society of MD, Inc. George MacNabb 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ INFARCTION MYOCARDIAL ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ORONARY ARTERY Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events CONGESTIVE HEART Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSIVE HEART DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC OBTRUCTIVE PULMONARY DISEASE 24a. Was an SIP CORONARY ARTERY BYPASS SURGERY 2007 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural
2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore, Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, To the Funeral Director: After this certific completed filled in by the funeral director, 24 hours Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in ring opinion, dean occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 29b. Signature and title of certifier 29c. License number 42522 12-20-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALAL Easter RAKASH MO 614-5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OROTH 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RTHWEST HOSP RADALLSTOWN 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours Min. (Month, Day, **02**, **01** Year) Director 217-40-1106 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21216 U.S.A. 3724 Chesholm Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 X Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Radiology Technician Hospital 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise Williamson Chester Ford Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westridge Road, Baltimore, Md 21207 6850 <u> Chester Ford-Brother</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 12/24/2010 Laurel, Md 4 Donation 5 Other (Specify) 21. Signatural of Funeral Service Liounsee 22 Name and Address of Facility 4360 Wabbash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications title caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or hear vailure. List only one cause on each line. Immediate Cause (Final ATKEROSCLERUTIC Onset and Death CARDIOVASCULAR Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 1 Yes funeral director, Be 25. Was case referre to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this May er of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending work? 1 🗌 Yes 2 🔲 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Ny Se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat and title of cer

Registrar

DHMH 17 Rev 7/2009

State

RUPP

21133

ause of death (Item 23a) (Type, Print)

DUD WUDT

32. Registrar Signatu

5401

MYNTO

0-09744			pe or Print in I						gible.	n 40432	
ugust Boblitz		1- For State	tate of Marylan	-		n nealth ai f Death	iu ivientai n		Some to 1		
Physici	an/	Registrar 1. Decedent's Name (First, Midd	dle,Last)		modic o	Douth	_	2. Date of De	Reg. No. ath	3. Time of Death	
Medical Exam		August	Boblitz					Month December	Day Year er 17, 2010	1740 hrs	
		4a. Facility Name (if not institution		er)	-	4b. City, Town, c	r Location of Deat	4c. County of	Death		
		Baltimore Washington	n Medical Center			Glen Burni	e		Anne Aru	ndel	
Funeral		5. Social Security Number	ar If Under 24Hr	_		Birthplace (State or Foreign					
Director		214-44-9837	1XM 2F		66 Yr	Months Da	ys Hours Hell	12/1	1/1944	Country) MD	
any		Usual Residence of Decedent 10a. State 10b. County		10c City T	own or Loca	tion				10d. Inside City Limits	
* .*			ne Arundel	i ou oky, i			Dagadasa			1 Yes 2 X No	
Maryland 28a-f show d at once.	cto	Maryland Anr 10e. Street and Number	ie Alumei			10f. Zip Code	Pasadena		10g. Citizen of Wha	it Country?	
5 72 hours after death with the Maryland 1"m "matural", or items 23a or 28a-f sho ral Examiner must be notified at once.	Director						21122		. 5	USA	
with the 18 23a C. noti		17 Holly Road	12. Was Decede	ent Ever in U.S	. 13. W	as Decedent of H	21122 ispanic Origin? (S	pecify Yes or N	o- 14. Race -	14. Race - American Indian, Black,	
leath '	Funeral	1 Never Married 2 M	larried Armed Force	es? 2 X No	lf `	Yes, specify Cuba	ın, Mexican, Puerto	Rican, etc.)	White,	etc.	
after c al", o	by F	3 Widowed 4 Div	vorced If Yes, Give Year or Dates:	_ [1] 110	1	Yes 2 N	o specify:		Specify:	White	
ours natur	pe pe	15. Decedent's Education (Spe					ation (Give kind of e. DO NOT use ret		16b. Kind of Busi	ness/Industry	
36 n 72 h	get	Elementary/Secondary (0-12)				CPA		,	Fir	nance	
15-0036 filed within 72 hours afte 1 Hygiene. ed other than "natural", t, the Medical Examiner	Completed	17. Father's Name (First, Middle	4 -1					(First Middle	Maiden Surname)		
4 - = 3 1	Be C	August F.		z Jr.			Genevi		Holton		
MD 2121 (2 should be fill h and Mental F 27 is marked aumatic event, 1	To E	1010							mber, City or Town,	State, Zip Code)	
Baltimore, MD 2: permit. Pages I and 2 should Department of Health and M Important: If item 27 is minjury or other traumatic e	۱ ا	Stephanie Latt	ta (sist	er)	17 I	Holly Ro	ad, Pasad	lena, MI	21122		
l and Heal		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal from		ace of Dispo ematory or o	sition (Name of ce	emetery, Dec	Date 20	20c. Location - C	City or Town, State	
MO Pages ent of int: I		4 Donation 5 Other S		State	_	matory I	- 1	2010	Baltimo	re, Maryland	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Servi				Name and Addres	A = 100	talling		al Home, P.A.	
@ 5241		de de	1-K d 1		_1_				sadena, MI		
Physician /Medical		23a. Fart I. Enter the disease, or failure. List only one cause		ed the death. D	o not enter	the mode of dying	, such as cardiac	or respiratory ar	rest, shock, or hear	Between Onset and	
ixaminer		Immediate Cause (Final disease or condition resulting in death)				liovascular Di	sease			Death	
			Due to (or as a co	nsequence of):							
	횰	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a co	nsequence of):							
executed in and il - transit		events resulting in death) Last	d.								
9 9 9	ical	UNPENDED	AMENDED								
Box 68760, e death certificate be the attending physici ed for use as the built		IF FEMALE:	23c. If yes, out	come of pregna	incy				23d. Date of de	elivery	
lox 687 eath certific	ian/	23b. Was decedent pregnant in the past 12 months?	Live Dilai	at time of deat	<u>, ~ = </u>	etal death 3	Ectopic pregna	ancy	Month	Day Year	
Box e death of the atter	Sic	1 Yes 2 No 9 Un	known 9 Unknown		" 5 <u> </u>	ther (Specify)					
c, th		Part II. Other significant condit	tions contributing to de	eath but not res	ulting in the	underlying cause	given in Part I.	23e. Did	tobacco use contribu	ute to the cause of death?	
i, P.O.	d by							1 Ye	es 2 No 3	Probably 4 🗸 Unknown	
Records, The law requir ficate has been s	Completed							24a. Was		ere autopsy findings available or to completion of cause of	
eco he law ite has	틹	-			-				orm <u>ed</u> ? de	ath? ✔ Yes 2 No	
tal Rec	B B	25. Was case referred to medica		_		26.Plac	e of Death (Check				
Vita hysicia this ce	8	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	atient 2 🗸 E	R/Outpatien	t 3 DOA	Other Nursi	ng Home 5	Residence 6	Other:	
J of Jing Ph After 1 funeral		27. Manner of Death 1 ✓ Natural	28a. Date of I (Month, Da	njury 2 y,Year)	8b. Time of	· · · _ ·	ury at Work?	28d. Describe	how injury occurred	i	
tiend trend death. tor: y the f	ati	Pen	stigation				Yes 2 No				
Division of Vital halo rate director: safer death. al Director: After this certical in by the funeral director.	Certification		ld not be	f Injury - At hom	ne, farm, stre	et, factory, office	building, etc.	28f. Location or Town,		or Rural Route Number, City	
- ig 8 g G		4 Homicide	(Opeany)						()		
294. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a control of the cause (s) and manner as a control of the cause											
To To Com	Medical	29b. Signature and title of certific	and manner state			29c. Licen				(Month, Day, Year)	
	-	6/11	1194	1	W)	0.0	M.E.		December 1		
	}	30. Name and address of person	who completed cause d	f death (Item 2	3a)				J		
			Assistant Medical	•	'	nn Street, Bal	timore, MD 21	201			
	_	24 2 4 51 144 4 2 4 4	22 Ponis	1 - 1 0: 1					-	·	

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010 40											40433	
	Physicia		Decedent's Name (First, Middle,	Melvin Os	car Ben						2. Date of Deat		10 ^{Year}	3. Time of Death 11:45 AM
	Medic Examin		4a. Facility Name (if not institution, s	give street and number) sing Home of M	t. Airy		4b. City, Tow	n, or L	ocation of Mt.				y of Death	arroll
	Funeral Director		220-20-4010	6. Sex 1 M 2 □ F	ge (In yrs. last birt 86	thday) Yrs.	If Under 1 Y Months D	ear ays	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Jun		9. Birth Coun	olace (State or Foreign ttry) VA
	aryland a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County MD An	nne Arundel	10c. City, Town	n or Loc	cation		Severr	na Pai	rk		1	I0d. Inside City Limits 1 ☐ Yes 2 No
	with the Ma 23a or 28 ust be noti	Funeral Director	10e. Street and Number 101 Avondale Circle	<u> </u>	<u> </u>		10f. Zip Co	de	211	146		10g. Citizen of	What Cour	ntry? ~
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Fun	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1944 5-1944) I	Yes, specify (Suban,	Mexican, Specify:	in? (Spec Puerto F	ecify Yes or No- Rican, etc.) 14. Race - Ameri Black, White, Specify:			etc. 1 t û
21215-0036	vithin 72 hou giene. er than "nat the Medica	Completed by	15. Decedent (Specify only highest Elementary/Seconday (0-12) 12		-	(Give F	lent's Usual Ockind of work do O NOT use reti Genera l	one dui ired)	ring most		·	16b. Kind of E	Business In	
Maryland 2	ild be filed v Mental Hyg rarked othe	To Be	17. Father's Name (First, Middle, La	Alfred Be	nson	son					ame (First, Middle, Maiden Surname) Pernille Gulder			
	and 2 shoule dealth and sm 27 is much traum		19a. Informant's Name/Relationship Stephen Benson	ip (Type, Print) SON		19b. Mailing Address (Street and Number or Rural Rout 1702 Orchid Lane Eldersburg, N Ob. Place of Disposition (Name of Date					g, MD 217	84		
Baltimore,	t. Page 1 a treent of F rtant: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Other (Sp	pecify)	e cemete	lantic	Cremator	place) y, LL	С	Dec	29, 2010	20c. Location		urnie, MD
Bal	permit Depar Impor any in		21. Signature of Funeral Survice Lie	HOldin	H01299.			Old	Colum	ibia Pil	ke Ellicott C		043	
	Physician/ Medical Examiner	23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart fail wit. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linipury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									Duse	Approximate Interval Between Onset and Death		
09289	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	resulting in death) Last	d.	a consequence	ot):								
. Box 68	t the death certifice by the attending p tached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death at time of death	al death 3 🔲 Ectopic pregnancy						23d. D	ery Day Year	
ds, P.O.	v requires that t been signed b should be deta		Part II. Other significant condition	ns contributing to death to Pneumonia racf In A	but not resulting i	in the u	nderlying caus	se giver	n in Part I.					ne cause of death?
Records,	: The law recate has be ; page 2 sho	Completed by	2003 to . D-Con	ract Influence Ulcer	Ection							med?	Were autoprior to codeath?	psy findings available mpletion of cause of 2 🖃 No
of Vital	g Physician: The er this certificate neral director, pag	te: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of inju	tient 2 ER/Ou ury 28b.1	utpatien Time of injury	t 3 🗆 DOA	6. Plac Other: Injury a work?	4 Mur	rsing Hor	only one) ne 5 Reside 8d. Describe ho			()
28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28c. Injury at work? 28d. Description 28d. Descr								28f. Location (St. City or Town		per or Rural	Route Number,			
	g g g g g g g g g g g g g g g g g g g										use(s) and manner stated.			
•	, , ,		29b. Signature and title of certifier		7	~	29c. Lic			23		9d. Date signe		
	Stat	te	30. Name and address of person who complèted cause of death (Item 23a) (Type, Print) Ndidi Feinberg, no 11165 Stratford Court 1St Floor Marriotts ville, ms									112, MD ZIICL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10f Per FH G910 12/22/10 JH. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 16, 2010 2:50 P Baumgartner Xaver Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Birthplace (State or Foreign Country)
 Cormany 8. Date of Birth (Month, Day, Year) March 3, 1909 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days 1 🖾 M 2 🗆 F Hours Director 127-12-3964 101 Germany Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State Director "natural", or items 23a or 28a-f sl dical Examiner must be notified 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20910 - 20904 United States 1024 Copley Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 XWidowed 4 Divorced Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Industrial Machinery Master Machinist 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H ပ Bachuber Maria Sebastian Baumgartner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 8711 Belmart Road Potomac, Maryland 20854 Robert Baumgartner/son permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/22/2010 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 thomas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 campa ox 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death days Immediate Cause (Final Physician/ Acute Hemorrhagic Stroke disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a ☐ Yes ∠ ☐ ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Chronic Kidney Disease Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Lung Cancer has page 2 s autopsy performe performed? Yes 2 2 No his certificate hil director, page 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) l e Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ၉ 1 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death.

Funeral Director: After this leted filled in by the funeral di

City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

D 0065485

121/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

reparrich.

M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910 Barbara Supanich, RSM, 31. Date filed (Month, Day, Year)
DEC 22 Registrar's Signa

State Registrar

Medical

RSM MID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PM Month . Physician/ Marie Josephine Braun Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rosadale Battimore Franklin Souare Hüspita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 💢 F Months Days Hours Min 213-14-9980 Yrs Balimore, MD 91 Director Dec Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits the Medical Examiner must be notified at Director Baltimore MD Baltimore 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 3109 Garden Avenue 21234 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married "natural", or 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
27 is marked other than Federal Government Elementary/Seconday (0-12) College (1-4 or 5+) Clerk 12 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Katherine Koerner Ferdinand Braun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar.
Important: If item 27 is u Barbara Germroth/ Sister 3109 Garden Avenue, Baltimore, MD 21234 December 23, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
OIY Cross
emetery 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, MD 21234 Signature of Funeral Service Licensee . Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Imn e late Cause (Final disease or condition Onset and Death Priysician/ Myocardia days а Medical resulting in death) Due to (or as a correquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): -burialattending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) Month Year Pregnant at time of death ned by the at edetached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Gastrointestinal Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy this certificate Yes 2 Division of Vital 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes မြ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manyler of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 | 3 | only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD (STEELE) 005 118/10

DHMH 17 Rev 7/2009

State Registrar FRANKlin Square Drive baltimore MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

aura Stee

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ANTHONY UMBERTO BADOLATO Physician/ December 20°, 2010 Year 7:10 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris Hospice . Age (*In yrs. last birthday*) Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex. 1 🛣 M 2 🗆 F If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours 217-03-4899 February 1918 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Maryland N/A Baltimore 1 K Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral or items 23a One West Conway Street, #1404 21201 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married X Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: White "natural", 3 X Widowed 4 Divorced WW 2 Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) US Government Transportation Manager 2010 To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Malatesta Michael Badolato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Joanne M. Millar (Daughter) 702 South Robinson St., Baltimore, Maryland 21224 Baltimore, ECEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 12/23/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 130 E. Fort Ave., Baltimore, Md. 21230 Signature of Funeral Service Licensee Kevin E Ecker 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ CONGESTIVE HEART FAILURE Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. **to the Funeral Director:** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year ANTHONY BADOLATO Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed? Yes 2 N 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 2 🗶 No HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD. MD 21093 TIMONIUM. 32, Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day GERALDINE DECEMBER 3:30 PM COWLING 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MEDICAL SYSTEM N/A UNIVERSITY OF MARYLAND BALTIMORE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 K F 0*697147*1928 Vi^{rg}inia 220-20-9097 Director 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore N/AMD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. 1133 N. Bentalou St. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Xidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education Bairding mainer brows to the (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Teacher Substitute vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Winnie Wells James Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1133 N. Bentalou St., Baltimore, MD 21216 Bryan Cowling(son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Cedar Hill Cem. 12/23/ 10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²Josephorn of Filtrown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD PA 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ PANCREATIC CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) Dav Year Pregnant at time of death g Unknown detach þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Inpatient 2 ER/Outpatient 3 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1093030546. MD 19,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH GREENE STREET, BALTIMORE, MD 21201 MICHAEL CHUNG 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore.

Box 68760

P.0.

Records,

Division of Vital

10-09815 Yun Choi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar			(Certifica	ate of	Death				Reg	g. No.			
Physician/	Decedent's Nam	e (First, Middle	e,Last)								Date of Death Month	n Day Yea		3. Time of Deatl	h
Medical Examiner	Yun Suh	Choi								[December	20, 2010		1122 hrs	
	4a. Facility Name (if not institution	n, give street and n	umber)		4	b. City, To	wn, or Lo	ocation o	f Death	4c. County of Death				
	Howard Co	unty Gener	ral Hospital				Colum	bia				Howard			
Funeral	5. Social Security N	lumber	6. Sex	7. Age (In y	yrs. last birth	nday)	If Under	1 Year	If Unde	r 24Hrs.	B. Date of Birth	(MM/DD/YYYY		place (State or	
Director	557-33-5		X		62) v	Months	Days	Hours	Min.	Aug 30	Foreign South Country) Korea]
			1 M 2 F			Yrs.	1		<u> </u>		Aug 30	, 1940 "NOLES			1
.	Usual Residence o	10b. County		110c	City, Town	or Locatio	on						- T	10d. Inside City	Limits
w any				1,00	•			011						1 Yes 2	VNο
Aaryland 28a-f show 1 at once. ector	Maryland	Howa	rd		1	TITIC	cott				140	g. Citizen of Wh			71
the Maryland or 28a-f sh tiffed at once	10e. Street and Nu	mber					10f. Zip (10	•		uy:	
the life	3205 Wh	eaton	Way Apt.C			21043						USA	1		
r death with or items 23s or items 23s must be not Funeral	11. Marital Status			cedent Ever	in U.S.						ify Yes or No-	14. Race White		an Indian, Black	Κ,
r iter	1 Never Marri	ed 2 X Ma	arried Armed F	-orces?	No	11 16	es, specify Cuban, Mexican, Puerto Rican, etc.)				can, etc.)				
Ker o	3 Widowed	4 Div	orced If Yes, Give Ye			1	Yes 2	No No	specify:			Specify:	Kore	ean	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done) 16b. Kir							16b. Kind of Bu	siness/Ir	dustry						
12 ho	15. Decedent's Education (Specify only highest grade completely) 16. Decedent's Education (Specify only highest grade completely) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnal Complete) 18. Mother's Name (First, Middle, Maiden Surnal Complete (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely) 18. Decedent's Education (Specify only highest grade completely)							G 16 T		1					
npl edicate			4			Sub (Contr	acto	r			Self E	mp To	oyea	
d win	17. Father's Name	(First, Middle,	Last)					18	3.Mother	s Name (F	irst, Middle, M	laiden Surname)		
215 be file ntal H. rked ent, til	Young G	il Cho	i						Jι	ing L	ee				
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than itic event, the Medical To Be Comple	19a. Informant's Na			-	198	. Mailing	Address	(Street	and Num	ber or Rur	al Route Numi	ber, City or Tow	n, State,	Zip Code)	
MD d 2 sho lith and n 27 is	Soon Du	ık Choi	Wife		13	205 1	Wheat	on W	Vav A	Apt.C	Ellic	ott City	, M	D 2 1 043	
and and tentile fram	20a. Method of Dis	position	, will		20b. Place o	f Disposi	ition (Name				Date	20c. Location -			
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Burial 2	X Cremation	3 Removal t	from State		-	ner place)	_		40.70	0/40	D 1. *		M . 1	1
Pag Pag ment tant:	4 Donation 5	Other Sp	pecify:		Metro	Cre	mator	y Ir	nc.	12/2	2/10			, Maryl	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Fu	ineral Service	License Thor	nas Gr	egor	Cr	emati	on S	OC16	ety O	f Mary	land, In ore, Man	nc.		
Ш 803.5	No	mai	17y			129	9 Fre	<u>deri</u>	<u>.ck F</u>	Road	Baltimo	ore, Mai	yla	nd 2122	8 Interval
Physician	23a. Part I. Enter the failure. List or	ne disease, or nly one cause	complications that	caused the d	leath. Do no	t enter th	ne mode of	ayıng, sı	uch as ca	ardiac or re	espiratory arre	ISI, SHOCK, OF HE	all	Between Ons	et and
/Medical:	Immediate Cause	Final disease	a Hypertens	ive Ather	osclerotic	: Cardi	Dvas cula	ar Dise	ease					Death	
Adminier	or condition resulti	ng in death)	Due to (or as	a consequer	nce of):										
	Sequentially list co	onditions,	b						_				_		
<u> </u>	if any, leading to in cause. Enter Under		Due to (or as	a consequer	nce of):								0		
Insit Examine	(Disease or injury events resulting in	that initiated	Due to (or as	a consequer	nce of):										
1) j. B Light M	events resulting in	death) Last	d.												
760, frate be executed the burial - transit	UNPENDED)	AMENDED												
760, icate be physicia the buris	LE EENALE.		220 If you	, outcome of	pregnancy							23d. Date of	delivery		
S is to all				birth		Fet	tal death	3	Ectopic	pregnanc	у	Month		ay Ye	ar
cia	past 12 month			nant at time			her (Speci								
the death certiful death certiful death certiful death certiful death certiful death for use as Physiciar	1 Yes 2	No 9 Uni	known g Unkr	nown											
t the ache		ificant condit	ions contributing	to death but	not resulting	g in the u	ınderlying	cause giv	ven in Pa	ırt I.		bacco use contr			
P.C es that igned be determined by		renal dise	ase, diabetes r	mellitus							1 Yes	2 🗸 No 3	Prob	ably 4 Unk	nown
Records, The law requires ficate has been signage 2 should be											24a. Was a			opsy findings av	
law r has b 2 sh											autops perfor	med?	leath?		
The cate											1 Yes 2	2 No 1	✓ Ye	s 2	No
Vital Records, P.O. Box 68 bysician: The law requires that the death certif this certificate has been signed by the attending all director, page 2 should be detached for use as To Be Completed by Physician	25. Was case refe	rred to medica								(Check on			7		_
Physic Physic ar this c		2 No	Hospital: 1	Inpatient								Residence 6			
Division of Vital Records, P.O. Box 68 tall or attending Physician: The law requires that the death certifins after death 10 Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as artification: To Be Completed by Physician									low injury occur	ea					
ice the father f	1 ✓ Natural 2 Accident	5 Pend	ding stigation					1 Ye	es 2						
livisi Lor At after d Direct d in by	3 Suicide		28e. Pla	ce of Injury	At home, fa	arm, stree	et, factory,	office bu	ilding, et	c. 21	8f. Location (S or Town, Si	street and Numb	er or Rui	al Route Number	er, City
Division o spital or Attending nours after death neral Director: After filled in by the function: Certification:	4 Homicide	dete	rmined (Specify	1)	_										
Hosp 24 ho Fune tely fi		Certifying P	hysician: To the be	est of my kno	owledge, de	ath occur	red at the	time, dat	e and pla	ace, and do	ue to the cause	e(s) and manner	as state	d.	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funcral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician	one) 2	Medical Exa	miner: On the basis		tion and/or i	nvestigat	tion, in my	opinion,	death oc	curred at t	he time, date a	and place, and o	lue to the	cause(s)	
F S F S F	29b. Signature and	title of certific			_		29c.	License	number			29d. Date sign	ed (Mor	th, Day, Year)	
	, O M	, (O.C.N	1.E.			December	21, 20	10	
5	30 Name and add	ress of person	who completed ca	use of death	(Item 23a)										
	Donna M.					111	Penn S	Street,	Baltimi	ore, MD	21201				
State															
State Registra	1 1 1 2 1 2 2	ZUIU	Geneur	Registrar's S	guero										

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Dorthy Margret Clark 08:11PM ecemb 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1519 Fountain Glen Dr. Bel Air Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F 75 Hours 213-32-3746 Director West Virginia June 11. Usual Residence of Decedent show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Direct 1 ☐ Yes 2 X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must b Funeral filed within 72 hours after death with 1519 Fountain Glen Dr. 21015 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 X Divorced Specify: White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Self Employed Elementary/Seconday (0-12) College (1-4 or 5+) Small Business Owner 12 Service Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be filed nt of Health and Mental Hi t: If item 27 is marked otl ည Joseph Menefee Edith Barr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Deborah Baker (Daughter) 1519 Fountain Glen Dr. Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel Air Memorial Gardens 20c. Location - City or Town, State Dec. 17, Department of Important: If it any injury or c 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signa of Funeral Service Lice 22. Name and Address of Facility & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 Part 1. Offer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 84/mond-y 1/589/2 Pnysician/ Obstructive 5Veav. Hrohil C disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to in reclate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 Month Pregnant at time of death 2 🔀 No ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 \(\text{Yes} \) 2 × No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifie

2010

31. Date filed (Month, Day,

22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regetrar's S

DHMH 17 Rev 7/2009

29c. License number

934 Aviation Blud 6/24 Burnie 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Melvin Curry, Jr. Month 2 9:38 AM 18 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Days 03/19/ Maryland 87 218-18-2863 Director 1923 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🛣 No Harford Havre de Grace Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 USA 128 Cooley Mill Rd. 11 Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ SpecifyWhite Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 0 Civilian Gunner Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Melvin Curry, Sr. Marie Frances Dudeck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Important If item 27 is any injury or other **-629 S. Rogers St., Aberdeen, MD 21001 Betty Phipps / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 \square Cremation 3 \square Removal from State 12/22/2010 Havre de Grace Rock Run Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral violation Tarring—Cargo Funeral Home, Parké St., Aberdeen, 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) BLADDER CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X 1 Yes 2 No 25. Was case referred to medical **Division of Vital** or Attending Physician: Be 26. Place of Death (Check only one) examiner's Other: 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide n 24 hours after which he Funeral Director: A Investigation 1 Tes 2 \square No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Carrifying Nursa Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date sighed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Yea

JACKIE JONES,

DEC 2 2 2010

CRNP

a.m.

9:38

2010

18,

DECEMBER

CURRY

CHARLES

anka

2300 DULANEY VALLEY RD.

TIMONIUM.

MD 21093

who completed cause of death (Item 23a) (Type, Print)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per verb., g910,12/22/2010dhb Certificate of Death Reg. No. for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician/ Davis 5:30 L W 619015 December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Battimore Hospice CNOVELINEST Landallstown tospita If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Months Hours 1 M 2 X F MD **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Baltimore MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Avenue 21216 USA Braddish 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Back 1 ☐ Yes 2 XNo Specify. 3 ⋈Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business Industry Baltinove City 15. Decedent's Education 16a Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools reacher Harade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ W. Miller Brown John Wueen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Braddish Avenue Baltimore MD 21216 awenddyn Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mimorial Park 20c. Location - City or Town, State 20a. Method of Disposition Date Surial 2 ☐ Cremation 3 ☐ Removal from State Windsor Mill, MD 29/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaugin C. Greene Funeral Services 21. Signature of Funeral Service Licenses au 8728 Liberty Road Rando Ustown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between (Alzheimers) Onset and Death Immediate Cause Final End. Stage Dementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Examir within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 👿 No ျင 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9 IsRy apalne M.D 12/17/10 DODS7465

Registrar

State

Parks

2835 Smilh AU.

32. Registrar's Signature

5-203-Baltimore, MD. 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N-S-Rajapakst, M.D

DEC 2 2 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day 14 Physician/ Month Year IZABETH DEBNAM DECEMBER 2010 10:10 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE PICE TOWSON If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 💢 F Months Days Hours Min 216-54-5209 Yrs Director Usual Residence of Decedent or items 23a or 28a-f shov 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location Director 1 ☐ Yes 2 No BALTIMORE WINDSOR MIL 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral Kettle U.S.A COUR 21244 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: BLACK Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 n and Mental Hygiene. SOCIAL SECURITY Elementary/Seconday (0-12) College (1-4 or 5+) CIERK ADMINISTRATION permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SMIT LBER OSTER 19a. Informant's Name/Relationship (Type, Parint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MARYIAND &1215 Street Apt. 402 mith BROTHER ANDREW 20b. Place of Disposition (Name of Kingm Memorator of Pkpl Gem. 20a. Method of Disposition 20c. Location - City or Town, State 12/30/10 128/2010 BALTIMORE, MARYIAND 22. Name and Address of Facility The DERRICK C. JONES 21. Signature of Funeral Service Lic AUE. BALTIMORE, MARYIAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year 2 Yes No sate has been signed by the page 2 should be detached g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 24 hours after death.

Funeral Director: After this certificate heleted filled in by the funeral director, pagi 2 🗆 No 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Certificate: To 2 [1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manyier of Death 28b, Time of 28c. Injury at work? 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) Ap, Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Si State Registrar

10-09635 Sylvia Dorsey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	(Certificat	e of De	eath		70	Re	g. No.		
Physicia	an/	Decedent's Name (First, Middle, Language)	ast)					l A	ate of Death	Day	Year	3. Time of Death
Andical Exami	ner		ORSEY					D	ecember	14, 20	10	1150 hrs
1		4a. Facility Name (if not institution, g	ive street and number)				r Location of	Death		4c. C	ounty of Death	
		4260 Nicholas Avenue	1-2			altimore		0.411 10	Date of Bird	h /1 41 4 /D D	N/A	nplace (State or
Funeral				yrs. last birthd		Under 1 Year lonths Day		Min.		(Foreign	MARYLAND
Director		219-60-5324	M _2[X]XF	5	6 Yrs.			0	8/22 <u>/</u> 1	1954	Cou	intry)
₩.		Usual Residence of Decedent 10a. State 10b. County	1100	City, Town or	Location							10d. Inside City Limits
w any		Toa. State Tob. County	100.	City, Town or	Location							1 X Yes 2 No
Maryland 28a-f show i at once.	ġ	MARYLAND N/A			BALTI				140	- Citizor	n of What Coun	
Mary r 28a ed at	Director	10e. Street and Number			10	f. Zip Code				3		u y :
with the Maryland ms 23a or 28a-f sho be notified at once		4260 NICHOLAS				2120					J.S.A.	T. Co. Division
th wil	Funeral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent Ever Armed Forces?	in U.S. 1			spanic Origir n, Mexican, F			14	White, etc.	an Indian, Black,
r dear	휪		1 Yes 2 X X I	No	1 Yes	OFT NO	one nife				BLA	CK
s after	٤	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year or Dates:	rd) 16a De		sual Occupa	ation (Give ki	nd of work	done		d of Business/Ir	ndustry
hour frat	ğ	Elementary/Secondary (0-12)	College (1-4 or 5+)				e. DO NOT u					,
36 hin 7, than tdical	쵤	8th grade		N	/ A						N/A	
5-0036 Jied within 72 hours at Hygiene. d other than "natural, the Medical Examin, the Medical Examin	Completed	17. Father's Name (First, Middle, La	st)	1 11	/ 11		18.Mother's	Name (Fire	st, Middle, M	laiden Su		
21215-0036 wild be filed within 7 Mental Hygiene, marked other than c event, the Medica	8	ROBERT L. DORS	SEY SR.				GENE	VIEVE	JOHNS	SON		
21. Sould B Men ic ev		19a. Informant's Name/Relationship	(Type, Print)	19b. l	Mailing Add	ress (Stree	et and Numb	er or Rural	Route Num	ber, City	or Town, State,	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shingury or other traumatic event, the Medical Examiner must be notified at once		Thomas Dorsey/	Son								land 21:	
G. l and l Heal		20a. Method of Disposition		20b. Place of I	Disposition y or other p		emetery,	Da	te	20c. Loc	cation - City or	Fown, State
TOP	Ш	1 Burial 2 X Cremation 3 4 Donation 5 Other Speci		METRO (12-2	0-10	BAI	TIMORE	, MARYLAND
Baltimore, permit. Pages I an Department of He Important: If ite injury or other to	- 1	21. Signature of oner specific Life	121				s of Facility				ERAL HO	
		11/2	allin		120	6 W NC	RTH A'	VE.				TE I.A.
Physician		23a. Par L Enter the disease, or cor failure. List only one cause on	plications that caused the d	eath. Do not e	enter the m	ode of dying,	, such as car	diac or res	piratory arre	st, shock	, or heart	Approximate Interval Between Onset and
∖/Medical ≟xaminer	Immediate Cause (Final disease a. Methadone Intoxication											Death
_xaiiiiiei	- 1	or condition resulting in death)	Due to (or as a consequer	nce of):							1	
	اء	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequer	ace of).				_			-	
	Examine	cause. Enter Underlying Cause	C.	100 017.								5-1
n :	Xa	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):							77	
executed an and al - trans	a		d	17 00	-		010 0	0 11				
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Medical	X UNPENDED	AMENDED 23a,2	27,28a-	-r pei	me g	912 2-	-2-11	VL			
760, ficate be g physici the buri	Š	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of 1 Live birth		Fetal de	eath 3	Ectopic p	oregnancy		1	Date of delivery onth D	ay Year
certi	ciar	past 12 months?	4 Pregnant at time	2 of death 5	=	(Specify)		or ogricino,		1		
Box 687 e death certific the attending r ed for use as th	Physician/	1 Yes 2 No 9 V Unknow	9 Unknown	-								
that the		Part II. Other significant condition	s contributing to death but	not resulting i	n the under	lying cause	given in Part	il.				he cause of death?
i, P.O.	d b							_	1 Yes	2 🖍 N	lo 3 Prob	ably 4 Unknown
ords, I	Completed							- 1	24a. Was a			opsy findings available ompletion of cause of
COI e law e 2 st	립								perfor		death?	
tal Rection: The certificate ector, page		25. Was case referred to medical	I			26 Place	e of Death (C	heck only		140	ı re	2 110
Division of Vital Records, P.O. Box 687 tallor attending Physician: The law requires that the death certific its after death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the content of the detached for use as the content of the detached for use as the content of the detached for use as the content of the detached for use as the content of the detached for use as the content of the detached for use as the content of the detached for use as the content of the detached for use as the content of	8	examiner?	Hospital: 1 Inpatient	2 ER/Outr	patient 3	DOA	lou			Residenc	e 6 🗸 Other	Scene
of Vit ing Physic After this	욘	1 Yes 2 No 27. Manner of Death	28a. Date of Injury		ne of Injury		ury at Work?	28d	. Describe h	ow injury	occurred	
nding r: Af	<u>5</u>	1 Natural 5 Pending	(Month, Day, Year)	. دعاً ۱	11.20	1	Yes 2X	No	nknowi	,		
isic Atte er dea rector	ical	2 Accident Investig	28e Place of Injury -				building, etc.		Location (S	treet and	Number or Rur	al Route Number, City
Div rs after led in	Certification:	3 Suicide 6 X Could no determin		house				42	or Town, St	ate) chola	as Ave.	Balto, Md.
Hospi 4 hou Funer ely fil			ician: To the best of my kno	wledge, death	occurred a	at the time, d	late and plac					
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Medical	one) 2 ✓ Medical Examir	er:On the basis of examinat and manner stated.	ion and/or inv	estigation,	in my opinio	n, death occu	urred at the	time, date a	and place	, and due to the	e cause(s)
F 3 F 8	Me	29b. Signature and title of certifier	, and the state of			29c. Licens	se number			29d. Da	te signed (Mor	th, Day, Year)
		Mounto Dr	e Moule,			O.C.	.M.E.			Decei	mber 18, 20	10
1111		30. Name and address of person wh	o completed cause of death	(Item 23a)								
prome		Margarita Korell MD.	Assistant Medical Exa	miner 1	11 Penn	Street, E	Baltimore,	MD 212	01			
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	11							
Regis	trar	DEC 9 2 2010	Bur A.	par	Car							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene, 28d, e, f per me, g910, 12/23/2010dhb, 20 yerb Certificate of Death Reg. No. For State Registrar 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret Dav 1602 Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore Medico 1 8. Date of Birth Jan . 16 , 1928 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours Marvland Director 207-22-0266 82 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Brandywine 1
▼ Yes 2 □ No MD Prince Georges 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20613 USA 13725 Martin Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Midowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) PG County School BD Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mattie Cleveland Brady Joseph Albert Ireland 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print)
19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18c. Name/Relationship (Type, Print)
19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18c. Name/Relationship (Type, Print)
19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19c. Name/Relationship (Type, Print)
19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number)
19c. Name (Number of Route Number of Route Number)
19c. Name (Number of Route Number 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite Howard University Medical School 1 🗆 Burial 2 🗀 Cremation 3 🗀 Removal from State injury or 4 X Donation 5 ☐ Other (Specify) 11/5/10 Washington, DC 21 Signature of Fun all Sovice Line nsee 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, NW, Washington, DC 20011 M00969 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physiciani disease or condition Due t' (or as a consequence of) Payallan Approved at wealth ex Medical resulting in death) Examiner zehemi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 10/17/10 with good Igpleon, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No Yes 2 N within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 □ No Other: ၉ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred
Subject driver of a vehicle
that collided with a vehicle injury ☐ Natural 5 Pending work? 1 ☐ Yes 2 ☑ No 12:00 PM 10/17/10 2-Accident Investigation 6 Could not be 3 Suicide 28e. Pla finjury - At hom farm, str. et, factory, offic ROAL WA Yetc. (Speci 28f. Location (Street and Number or Pural Route Number City or Town, State brandywine and North 4 Homicide determined City or Town, State Brandywine, and No. City or Town, State Brandywine, MD Keys Road, to Keys Road, Drandwine, Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25640 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L0000 22 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

79941

Please Type or Print in Black II. lible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Pear December 20, 2010 **Physician** 5:50A. M Virginia Dinisio W. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Genesis ElderCare-Heritage Dundalk 9. Birthplace *(State or Foreign Country)*Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 XF Feb15,1926 84 Director 216-20-0992 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County ed other than "natural", or items 23a or 28a-f show event, the Medical Examination must be notified at 1 ☐ Yes 2 X No Baltimore Dundalk Director Md. 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 should be filed within 72 hours after death with to and Mental Hygiene. Is marked other than "natural", or items 23a or? 1801 Tolson Avenue 21222 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐Yes 2 ☐ No Specify Specify: White <u>م</u> 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A & P Clerk 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last(unk) Be Virginia Marriott ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 202 Waterford Lane Winchester, VA. 22602-6224 Walter Wayne McCarthy/son of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 23,2010 Gardens of Faith Baltimore, Maryland 22. Name and Address of Facili Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure! List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) Due to (or ARCINOMAOFLUNGS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) burialphysician sthe burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part 1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Q Q 0 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manual of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🗁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature

Registrar

DHMH 17 Rev 1/2001

Saltimore, Maryland 21215-0036

be executed

Box 68760,

Ö

۵.

Division of Vital Records,

31. Date filed (Month, Day, Year) State

32. Registrar's Signature

od cause of boath (Item 23a) (Type, Print)

DEC 2 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Engle Edwin Wilson 2010 Dec. 11:00 18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 155 South Grundy Street Apt. 207 Baltimore City 8. Date of Birth (Month, Day, Year) March 14,1924 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 🗓 M 2 🗆 F 216-18-6258 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if fire 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Marked of the property or other traumatic event. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Baltimore City MD N/A 1 X Yes 2 No 10e. Street and Number 10g, Citizen of What Country? Completed by Funeral United States 21224 155 South Grundy Street Apt. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married tycxYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced White Year or Dates. WWII 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturing Scaleman 7 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mae Gloria Dorsey David Wilson Engle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3701 N. Point Road Lot 32 21222 Dundalk, MD Mrs. Carolyn J. Miceli(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp. 12/22/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
Duda-Ruck Funeral Home of Dundalk,
Maryland 21. Signature of Funeral Service Licenses Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure list only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) ☐ Yes ∠ ☐ ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page 2 performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify) Hospital: Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☑ No Investigation Accident 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 3 🗌 only ahe) 29b. Signal 29d, Date signed (Month, 038635 - SA

State Registrar M. USYAVAR

31. Date filed (Month, Day, Year)

41

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

9600 MRIH

32. Registrar's Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Floyd William Estes 10:45 A^M December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1807 Redfield Road Harford Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Oct. 20 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 24 Hrs **Funeral** 1 AM 2 □ F Days Hours Min Months 454-32-6628 85 Yrs Director Texas Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatin a work the state of the state 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1807 Redfield Road 21015 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 □ No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Seconday (0-12) College (1-4 or 5+) 8 Manufacturer Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Albert Estes Esta Elizabeth Bigham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda B. Estes / Wife 1807 Redfield Road, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Reproval from State Dulaney Valley Mem. 12-23-10 Timonium, Maryland Donation 5 Other (Specify) re of Fur McComas Funeral Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. val Retween et and Death Immediate Cause (Final Physician/ 0000 CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Yes 2 No. 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 death? After this certificate I 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mariner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending atural Accident
Suicide 1 🔲 Yes 2 🗌 No filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I completed filled Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) クナイスエンエスト DECEMBER 00028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATMOOD ROAD, BIZL ATR 602 MO 21014 NI 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

0-09388		Please Type or Print in Black Indelible			e.
Barbara Ann East	1	State of Maryland / Department -For State Certificate Registrar		⊣ygiene Reg. No	2010 - 0 - 8
Physiciai Medical Examin	n/	1. Decedent's Name (First, Middle, Last) Barbara An Easter		2. Date of Death Month Day December 6, 2	3. Time of Death 2000 hrs
		4a. Facility Name (if not institution, give street and number) 2721 Presbury Street	4b. City, Town, or Location of Dea Baltimore		c. County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	in	//DD/YYYY) 9. Birthplace (State or Foreign
Director	-	2/2-44-1/53 1 M 2 F 65 Usual Residence of Decedent	Yrs. World's Days Hours W	Mar. 27,1	1945 Country) Mary 1919
ow any	ľ	10a. State 10b. County 10c. City, Town or Lo	Baltimore	· ·	10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	10f. Zip Code	10g. Cit	tizen of What Country?
5-0036 ed within 72 hours after death with the Maryland tygiene. other than "natural", or items 23s or 28s-f she the Medical Examiner must be notified at once	<u>a</u>	2721 Presbury St. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No-	USA 14. Race - American Indian, Black,
r death v	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puer		White, etc.
ours afte	<u>اھ</u>		Yes 2 No specify: dent's Usual Occupation (Give kind of a most of working life. DO NOT use re		Specify: The Third of Business/Industry
D36 thin 72 h ne. than "n tedical E.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Disabled)	NA
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Meditan	ည် မ	17. Father's Name (First, Middle, Last)	18.Mother's Nar	ne (First, Middle, Maider	n Surname)
	PB PB	19a. Informant's Name/Relationship (Type, Print) 19b. Ma Tackie Mason—Niece 27.	ling Address (Street and Number o	r Rural Route Number, C	City or Town, State, Zip Code) 21216
mand 2 calth cen 2 cen 2 cen 2 cen 2		20a. Method of Disposition 20b. Place of Dis	position (Name of cemetery, rother place)	Date 20c.	e Maryland Location - City or Town, State
Limore Pages I: Iment of H tant: If it	ı	4 Donation 5 Other Specify:	awn Memorial 10	413/10 E	Emporia, Viginia
Baltim permit. Pag Department Important: injury or o	ļ	21 Signature of Funeral Service Licenses	2. Name and Address of Facility 13 3572 Frederick 1	Kertynera Ave. Balti	nore Klaryland
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not entrailure. List only one cause on each line. Immediate Cause (Final disease a Hypertensive Cardiovascular Disease)		or respiratory arrest, sh	ock, or heart Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	lease		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.	· · · · · · · · · · · · · · · · · · ·		
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
execul	둉	UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be exhin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician poletely filled in by the funeral director, page 2 should be detached for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg		d. Date of delivery Month Day Year
Box 687 e death certifu	ysici	1 Yes 2 ✓ No 9 Unknown 9 Unknown	Other (Specify)		
P.O.	ģ	Part II. Other significant conditions contributing to death but not resulting in the Diabetes mellitus	ie underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death? No 3 Probably 4 Vunknown
of Vital Records, P.O. ag Physician: The law requires that the faw requires that the fact this certificate has been signed by moral director, page 2 should be detact.	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ital Records ician: The law requi s certificate has been rector, page 2 should		25. Was case referred to medical	26.Place of Death (Chec	performed? Yes 2	
Vital F hysician: this certifi	ĕ	examiner? 1 ✓ Yes 2 No Hospital 1 Inpatient 2 ER/Outpati	ent 3 DOA Other Nurs	sing Home 5 Resid	ence 6 🗸 Other: Scene
ion of tending Ph eath.		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time	of Injury 28c. Injury at Work?	28d. Describe how in	ury occurred
Division pital or Attendia ours after death. filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	treet, factory, office building, etc.	28f. Location (Street or Town, State)	and Number or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or (Check only)			
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated. 29b Signature and title of certifier	29c License number		Date signed (Month, Day, Year)
		Calmert (1 M)	O.C.M.E.	De	cember 10, 2010
5			enn Street, Baltimore, MD 2	1201	
Sta Registr	-	31. Date filed (Month, Day, Year) DEC 2 2 2010 32. Registrar's Signature	and and		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Deborah Regina Franks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2 □**X**€ Months Days Hours Min. 03/28/1945 Director 212-44-9720 65 Usual Residence of Decedent or 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 133 W. Henrietta 21230 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or Be Completed by If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Johns Hopkins and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital 12th Grade Nursing Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Joseph Spruell Myrtle Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Trevor Spruell(son) 1405 Hardwick Dr. Apt. K.Balto..MD 21221 altimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Jesett Fremation of other pand Cremation 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or unk Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 www 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) arrhythmia Medical Due to (or as a nsequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Dav Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? recurrent Gibleeding 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Director: After this certificate 1 Yes 2 PNo Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number DOO62689 December, 18,2010 athleen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen h. Shaffer mh

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)
DEC 22 2010

2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Year Physician/ Month DEC. Day 1:26P 19 BETTY INEZ FITCH Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE STELLA MARIS HOSPICE TIMONIUM 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Sc. 2, 1932 Days Hours Min. 1 □ M 2 🗓 F 219-30-1156 78 Dec. Director Usual Residence of Decedent 10b. County or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director Baltimore County Baltimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 items 23a 1342 Evering Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes XX No
If Yes, Give
Year or Dates. Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", Completed 3XXWidowed 4 ☐ Divorced injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) 12 yrs. life. DO NOT use retired) College (1-4 or 5+) I Hygiene. B. J.'s Wholesale Demonstrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ပ္ David Stewart Goldie Stuart permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30651 Brandywine Ct. Salisbury, Md. 21804 David L. Leineweber (Son) DECEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 12-23-2010 Gardens of Faith Baltimore, Md. 4 Donation 5 Other (Specify) 7401 Belair Rd. ^{22.} Name and Address of Facility Lassahn Funeral Home Signatur of Funeral Service Lige Baltimore, Md. 21236 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Dub to (or as a consequence or). Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate has ral director, page 2 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: within 24 hours after deau.

To the Funeral Director: After 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital

State Registrar

Medical

29a. Certifie

only one) 29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP

DHMH 17 Rev 7/2009

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Underlical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TIMONIUM.

MD 21093

29d. Date signed (Mortth, Day, Year,

20/ 0

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louise Fuss December 20. 2010 9:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care Canton Harbor Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months 215-24-8323 February 19, 1926 Woodstock, maryland **Director** 84 Usual Residence of Decedent 28a-f shov with the Maryland 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8152 Kavanagh Road 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: White and Mental Hygiene.
is marked other than "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 3 years Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David S. Jenkins Artie McDaniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Mary Tyler 8152 Kavanagh Road, Dundalk, Maryland daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 23, 2010 Signature of Funeral Service Licen Ae ^{22. Name and Address of Facility}
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. NI Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure use only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ End Demen disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine Due to (or as a consequence or). ri any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mo Day Year Pregnant at time of death be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wilknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 Yes 2 Ho Yes 2 No director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Tyes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month. M.D. 63540. 211 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 204 Parkville MD 21234 Shah 8413 Walman

DHMH 17 Rev 7/2009

State Registrar filed (Month, Day, Year IEC 2 2 201

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	•	State Registrar	otato .	or maryic		tificate of	Death	Wichtairi		. 1 .		4 }
Dharisis		1. Decedent's Name (First, Middle	, Last)					2. Date of D	eath	Reg. No. 3. Time of Death		
Physicia Medic		Barbara Ann Forbes						Decembe:	r 18, 2010	O Year	8:00	a ^M
Examin	er	4a. Facility Name (if not institution,		mber)		4b. City, Town, o	or Location of Deat			nty of Death		
- f		Forest Haven Nursi					Catonsville Baltimore					
Funeral Director		212-76-1135 Usual Residence of Decedent	6. Sex 1 M 2 F	7. Age (In yn	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of B (Month, D Novembe:	rth ay, Year) r 15, 1943	0	place (State o stry) Land	or Foreign
nd show	៦	10a. State 10b. County		10c.	City, Town or Loc	eation				- 1	10d. Inside Ci	ity Limits
faryla 8a-f s iffied	ect.	MD Baltim	ore	Cat	onsville					- 1		s 2 🖈 No
the N	٥	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cour	ntry?	
s 23a nust b	Funeral Director	701 Edmondson Avenu	ue			21228			USA			
death item	E.	11. Marital Status	Armed F	edent Ever in orces?	U.S. 13. V	Vas Decedent of F Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No to Rican, etc.)	- 14. R	ace - Americ		
after after al", or xami	d by	1 Never Married 2 Marr Married 2 Marr Married 2 Marr	If Yes, Gi			☐ Yes 2 🗓 No			Speci			
5-0(hours natur lical E	lete	15. Deceder	Year or D		16a. Deced	ent's Usual Occup	pation		16b. Kind of	WITTU		
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	(Specify only highe Elementary/Seconday (0-12)	st grade completed College ((Give k	ind of work done O NOT use retired;	during most of wo.	rking	100.14.11.00	D40//1000 1111	addit y	
1 with ygien her th	ത	6			Assista	ant			Beauty S			
and be file ntal H ed ot	To B	17. Father's Name (First, Middle, L Irvin Forbes	ast)					me (First, Middle		me)		
Iryla buld b d Me mark matic		19a. Informant's Name/Relationsh	nin /Timo Print)		1			Brickhous				
		Marian Shenton	sister		601 Blo	ossom Lane	and Number or Ru Glen Burni	ie, Maryla	er, City or Town, and 21061	, State, Zip (?ode)	
Baltimore, eernit. Page 1 and Department of Hea mportant: If item any injury or other		20a. Method of Disposition 1 Description 2 Cremation	3 Removal from	n State	•	atory or other pla		Date	20c. Location	-		
Hin hit. Pa artmei artmei ortani injury		4 Donation 5 Other (S		Ce	dar Hill (Cemetery	Decen	nber 21, 2	1910 Broo	klyn, 1	4aryland	<u>1</u>
Department of the same of the		21. Signature of Expercil Service	MACO		237	. Name and Addre 7 East Pat a	ess of FacilitMcCu apsco Avenu	ılly Polyr ıe Baltimo	uiak Funer ore. Marvl	cal Home	e P.A. 225	
		23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that	caused the de						CHRI 212	Approximate	te
- Physician/		Immediate Cause (Final disease or condition	my one cause on e	acii iiile.		(e	eloval	nals		Į.	Onset and I	
Medical Examiner		resulting in death)	a. Due to	(or as a conse	equence of):	<u> </u>	C100-C1	house			Years	
	7	Sequentially list conditions,	b. ———					3				
cuted nd ransit	kamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	(or as a conse						7)		
8760 ifficate be executed up physician and as the burial-transit	Medical Examiner	resulting in death) Łast	Due to	(or as a conse	equence of):							
8760 tificate br ng physic		IF FEMALE:			1000							
Box 68 death cert cert cert cert cert cert cert cert	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, ou	Birth 2 F	etal death 3	Ectopic pregnan	су			Date of deliver	-	Year
. B G he dec	ysic	1 ☐ Yes 2 █ No 9 ☐ Unknown	9 Unk	gnant at time o nown	or death 5 L	Other (specify) _			"	NOTITI	Day I	leai
P.O. that the ned by e detack	by P	Part II. Other significant conditio	ns contributing to	death but not r	esulting in the ur	nderlying cause gi	ven in Part I.	23e. Did	tobacco use coi	ntribute to th	e cause of de	eath?
ds, luires en sign	edb							1 🗆	Yes 2 No	3 🗌 Prot	oably 4 🗌 I	Unknown
Soro	plet							24a. Was		. Were autor	osy findings a	available
Re(Completed							auto perf	ormed? 2 - No	death?	mpletion of ca	ause or
tal cian:	Be	25. Was case referred to medical examiner?	Usanitali				lace of Death (Che					
f Vi	은	1 Yes 2 No			ER/Outpatien		4 Nursing I	Home 5 ☐ Res)	
Division of Vital Records, tal or Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be a should be	Certificate;	1 Accident Investig 3 Suicide 6 Could	ation	of Injury oth, Day, Year)	28b. Time of injury	28c. Injur work M 1		28d. Describe	how injury occu	rred		
Divis tal or At rs after o al Direct ed in by	Cert	4 Homicide determi	28e. Place	e of Injury - At ing, etc. (S <i>p</i> ec	home, farm, stre	et, factory, office			Street and Num wn, State)	ber or Rural	Route Numb	er,
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 ☐ Medical Ex	Physician: To the baxaminer: On the bax Nurse Practioner:	sis of examinat	ion and/or investi	gation, in my opinie	on, death occurred	at the time, date	and place, and d	lue to the car	ise(s) and mar	nner stated.
To the confidence of the confi		29b. Signature and title of certifier				29c. Licens	e number		29d. Date sign	ed (Month, L	Day, Year)	
		P)	03757	7.7	Vece	nber	20,20)/0
7		30. Name and address of person w	who completed cau	e of death (Ite	em 23a) (Type, Pr		th Az	e Ba	Hime	Mo	2120	, o1
Stat	<u>ح</u> ا	31. Date filed (Month, Day, Year)		Registrar's Sign	nature	Kel				, . , •		-
Registra		DEC 223	2010 /2	ma.	1. par	Kel						
DHMH 17 Rev 7/20	09	700 200	1-00		3.0							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per th g9111-19-11 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1^{Month} 2010 Geiger 18 6:15p Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4604 Norfolk Ave Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Manth, Day, Year) Birthplace (State or Foreign Country) **X**□ M 2 □ F Months Days Hours Min. Yrs **Director** 249-20-4440 86 18 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 10d. Inside City Limits MD NA 1X Yes 2 No Baltimore 10e. Street and Number Ъ 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 4604 Norfolk Ave 21216 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Black 3 Divorced 4 Divorced Specify: Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 72 nt of Health and Mental Hygiene.

E If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade Steel Beth Corp Crain Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Garrison Geiger Lula Geiger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Evette Geiger-Daughter</u> Norfolk Ave. Baltimore. Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2010 Owings Mills, Md Garrison Forest Vėt 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ 0/00 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause (Disease or linjury Due to (or as a consequence or). been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year ☐ Yes ∠ ∟ ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/of investigation, in this opening, detailed by the cause (s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29c. License number 2+1 who completed cause of death (Item 23a) (Type, Print) 7141 Security Baltimore 31. Date filed Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Physician/ Month 4:30 P M Lewis P. Green, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1434 Homestead Street Baltimore If Under 1 Year If Under 24 Hrs 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F 58 Hours Country) 217-58-8666 Director 12-5-1952 MD Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland items 23a or 28a-f sho her must be notified at Director 1 ¥ Yes 2 ☐ No MD na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21218 1434 Homestead Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status the Medical Examiner Armed Forces? Black, White, etc ō þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Black 1 Yes 2X No Specify If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry Il Hygiene. life. DO NOT use retired)
Laborer Bond Plaster Gold Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade event, i Be filed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ည Lewis P. Green, Rosalee Steedley traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 1434 Homestead Street Balto, MD Lewis P. Green, Sr-Father other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗶 Burial 2 □ Cremation 3 □ Removal from State ò Department or Important: If any injury or once. 12-22-2010 Anne Arundel Co, MD Cedar Hill Cem 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 22. Name and Address of Facility Signature of Funeral Service License 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (ui as a conseque n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) g 🗌 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' After this certificate 1 Yes 2 No Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 5 Pending work 1 Yes 2 No Accident Investigation Director: / 2 Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check at the time, date and clade, and due to the gause(s) and mawithin 2 To the I Certifying Nurse Practioner: To the bi 29b. Signat d title of certifier 29d. Date signed (Month), Day, Year)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Gunter 228 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death North west Baltimore Randalls town 5. Social Security Number 8. Date of Birth (Month, Day, Apri 1 6. Sex If Under **Funeral** 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days 1 □ M 2XX 78 Director 212-30-6376 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified MD Baltimore Owings Mills 1 Yes XX No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 17 Walk Ave. 21117 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X XNo
If Yes, Give Completed by 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H .. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o မ Harry R. Dieh1 Beulah Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William James Gunter/Husban¢ 17 Walk Ave. Owings Mills, MD 21117 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evergreen, Memoria 1
Gardens 20a. Method of Disposition 20c. Location - City or Town, State <u>i</u> 1XXBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or 4 Donation 5 Other (Specify) 12.24.10 Finkesburg, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that initiated events resulting in death) Last attending physician and the burial-tran Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 A M 1 Inpatient 2 A/Outpatient 3 I DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 \square Pending 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 00062650 12-21-10

Registrar

DHMH 17 Rev 7/2009

State

100

1 andallstown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(7a)

anuye

31. Date filed (Month, Day, Year)

421

DID CONA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 5:04P M James Gregory December 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death BACTIMORE SAINT Agnes HosoItAl Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Jan 18, Birthplace (State or Foreign Country)
 VA **Funeral** 1 XM 2 🗆 F Days Director 227-34-7374 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 N. Denison St 21229 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th RailRoad Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Lee Gregory Alice Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Gregory/Wife 111 N. Denison St. Balto., MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St Paul Ch Cem 12/27/10 Boydton, VA 22. Name and Address of Facility Beverly D. Cromartie F/S21. Signature of Funeral Service Licenses 700 Edmondson Ave. Balto.. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final infarction Onset_and Death Mypcardal Physician disease or condition resulting in death) UNWOUND Medical Due to (or a consequence of) Examiner Sequentially list conditions. Due to for as a conse, tience if cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Tes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner To the best of my knowledge, death oneum 29b. Signature and title of certifier 04735 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 Caton Avenue aleic, Mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bark Registrar

AMes

regor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 16, 2010 5:27 A M Physician/ Harriet E. Gordon Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Parkville Oakcrest 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🟋 F Months Octonth 4 4 1918 Maryland 216-07-8601 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f sho must be notified at Director 1 🗆 Yes 2 🗓 No Baltimore Parkville MD 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number 21234 Completed by Funeral 8800 Walther Blvd USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. the Medical Examiner 1 Never Married 2 Married ō Specify: white Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🗷 No Specify: 3 K Widowed 4 Divorced Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) At Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Montal High Important: If item 27 is marked oth any injury or other traums**-17. Father's Name (First, Middle, Last) Katherine Roeder 2 Harry Roberts 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zio Code)

18 Bramble Lane-Churchville, Maryland 21028 19a. Informant's Name/Relationship (Type, Print) Katherine Steinmetz-daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Evans Funeral Chapel and Cremation-Belair December 1 Burial 2 Coremation 3 Removal from State Forest Hill, Maryland 17 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Chapel and Cremation Services Road-Parkville, Maryland 21234 Funeral Harford -consora 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Debuty
Due to (or as a confequence of): Physician/ disease or condition resulting in death) Medical **Examiner** Alzhermes Disease Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician ar s the burial-t Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Dav been signed by the should be detached Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 110 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ြို 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 27. Manner of Death 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signature and time R171944 G Horrison (Days and Sa) (Type, Print) 8800 Walther Blud, Parkville, MO 21234

State Registrar

Michaelle 31. Date filed (Month, Day, Year)

Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year HORM 10.52AM 2010 Medical 1 6 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Parla more Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Days Hours Min. . Carolina 09^M/11^D/11^D/11^D/126 250-48-6433 84 N. Director Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Tes 2 X No MD Baltimore co. Baltimore ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 72 King Henry Circle 21237 S.A. death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc 0 þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 6th Grade construction <u>Genstar</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unk traumatic unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 72 King Henry Circle, Baltimore, MD 21237 Lavonne Dixon(stepdaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Jesephery rematory or ether placel F/H and Crematory 1 Burial 2 M Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/20/10 Baltimore, MD 21. Signature of Funeral Service Licensee ²ට්ර්පීප්ට්ර්ජ් ස් ා f B byown Jr. Funeral Home PA ellam 2140 N. Fulton Ave., Baltimore, MD 21217 - 11 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Acuta disease or condition resulting in death) Conc 425 Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence or): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I 4 Jursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident 1 ☐ Yes 2 ☐ No Investigation

Box 68760 P.O. Records, I or Attending Physician: after death. Division of Vital Director: After filled in by Hospital within 24 hours To the Funeral 흔

4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence of the basis of examination and/or investign only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence of the basis of examination and/or investign only one)	ation, in my opinion, death occurred	at the time, date and place, and due to the cause(s) and manner stated
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
5 2 5 5 5 5	062757	December 12, 2010
30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	nt)	
Deepak Baskeran 3455 W	illey Are	LUID Baltimor MD 2/223

Registrar DHMH 17 Rev 7/2009

State

UEC 2 2 2010

Deneur

Medical

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 2005 2010 -ord 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth If Under 1 Yaar Pediath(Washington Number 6. sa Baltimore Baltimore 1 Yaar If Undar 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Dey, Yaar) Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 5. Social Security Number Months 1X M 2 F 03 13 2010 9 216-87-1824 Usual Residance of Decedent 10d. Insida City Limits 10b. County 10c. City, Town or Location 10a. Stata 1 ☐ Yes 2 1 No Owings Mills Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 U.S.A. 9 Saddlestone 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ♣☐ No If Yes, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, etc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Naver Marriad 2☐ Married Black 1 ☐ Yas 2 🗓 No Specify 3 Widowed 4 Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highest grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) N/A N/A N/A N/A 18. Mother's Nama (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Royisha Williams Mark Anthony Harps 19b. Mailing Address (Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Saddlestone Ct., Owings Mills, Md 21117 9 Royisha Harps-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State King Memorial Park 12/23/2010 Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 e, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrast, List only ona cause on each line. Approximata Intarval Batwaan Onsat and Daath Immediata Cause (Final disaasa or condition rasulting in death) Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Ceuse (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequenca of) Dua to (or as e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 2DNo 3 Probably 4 Unknown 1 Yes 24b. Wara autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yas devere

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be axed ted Division of Vital Records, P.O. Box 68760,

Depertment of Important: If it any injury or concept.

Physician

/Medical

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Hastilt and Mental Hygiene.
ant: If Itam 27 is marked other than "netural", or items 23a or 28a-f show ury or other traumatic event, Tra Medical Exp. Inter rest be a cultined at ury or other traumatic event, Tra Medical Exp. Inter rest be a cultined at

Saltimore, Maryland 21215-0020

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

2

Completed

Be

MD

Physician/Medical Examiner Be Completed by edicai Certification: To

Director: A within 24 hours after de To the Funeral Directo completaly filled in by the

25. Was casa refarred to medical examinar? 27. Manner of Death

> 29a. Cartifiar (Check only one) 29b. Signatura and titla of certifier

1 | Yas 2 | 1 | 10

2 Accidant

4 T Homicide

3 ☐ Suicida

1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and mannar stated.

5 Pending invastigation

6 Could not be datarmined

28c. Injury at Work?

1 Yas

2 🗌 No

26. Place of Death (Chack only ona)

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify)

28d. Describe how injury occurred

29d. Data signed (Month, Day, Year)

28f. Location (Straet and Numbar or Rural Routa Number, City or Town, State)

30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print)

Lake ave, Balt- mD 1141 TIKER

Hospitel: Inpatient

28e. Data of Injury (Month, Day Yaar)

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

After this

death.

2 ER/Outpatiant 3 DOA

28b. Tima of

28a. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Î\$ 20ÎÖ Louella Horne 2:50 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Balto Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 - M 2 - F 5-20-1932 246-42-6057 **Director** 78 N.C. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified XXYes 2 No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1308 Walters Avenue 21212 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Coilege (1-4 or 5+) 12th grade Janitorial NSA Fort Mead Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hill Mamie Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Novice Horne-Daughter 1308 Walters Avenue Balto, MD 21239 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Garrison Forest 12-27-10 4 - Ohation 5 - Other (Specify) Owings Mills, 21. Signate o Funeral Service Licensee 22. Name and Address of Facility March East F/H will. 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) NECROTIZING FASCIITIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 X No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; A
completed filled in by the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 . Date filed (Month, Day, 32. Registrar's Signature State DEC 2 2 2010 Registrar

DHMH 17 Rev 7/2009

p.m.

DECEMBER 19, 2010 11:20 p.m.

BETTY HAISLOP on of Vital Records, P.O. Box 687

			For State	Plea amend	se Type o l #10e _{at} e1	r Prir & Ma	nt in E	GB B	artifica 861	Health	n and N	II Copie Mental Hy	es Ar /gien	e Legi e	ble.	
			Registrar					Cer	tificate of	Death	7		Reg. N	No. 2	01	0 1045
	Physici Medi			Jane Ha	islop							2. Date of D Month De		Day Oer 19	Year 2	3. Time of Death
T	Exami	ner	4a. Facility Name (i Stella		give street and nu Hospice	mber)			4b. City, Town, c		n of Death uther	ville Baltimore 18. Date of Birth 9. Birthplace (State of				
	Funeral Director		5. Social Security N 235-50	-5569	6. Sex 1 □ M 2 🗹 F	7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Und Hours	der 24 Hrs. Min.				hplace (State or Foreign intry) est Virginia	
	yland f show ed at	tor	Usual Residence o 10a. State	10b. County			10c. City,	Town or Loc	cation							10d. Inside City Limits
	the Mar a or 28a- be notifi	Funeral Director	MD 10e. Street and Nu	mber	timore		F	arkvi	10f. Zip Code				10g. Citizen of What Co			1 Ves 2 No untry?
	n with	Je.	1919 W	ildwood	Avenue				212:	34				Unite	ed S	States
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event; the Medical Examiner must be notified at once.	d by Fu	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed		12. Was Dec Armed F ed 1 Yes If Yes, Gi Year or D	orces? 2 2			Vas Decedent of H f Yes, specify Cuba Yes 2-1000			cify Yes or No Rican, etc.)	•		- Amer , White	rican Indian, e, etc. White
Maryland 21215-0036	n 72 hours s. a n "natur Medical I	Completed by	(Spi			1)	,	(Give F	lent's Usual Occup kind of work done O NOT use retired)	during m	ost of worki	ng	16b.	Kind of Bus	siness I	
21	withii giene er th		12		College (1-4 01 34	⁻	Но	me Maker					Own H	-lome	•
b	filed al Hy d oth	Be c	17. Father's Name	(First, Middle, La	ıst)							(First, Middle	,	,		
<u>Ja</u>	d be Menta arked atic e	은	Walte	r Nelsc	n						Dewey	Unk S	1ay	ton		
	nd 2 shoul salth and I n 27 is m		19a. Informant's N Charle		p (Type, Print) .op /Husba	and			g Address (Street 13 Wildw							
Baltimore,	Page 1 ar nent of H ant: If iter ary or oth				3 ☐ Removal from	n State	cei	metery, crem	sition (Name of natory or other place ke Cremate			Dec 21 2010	20c.	Location - C	•	Town, State
Balti	permit. Departr Importa any inju	1	21. Signature of Fu	neral Service Lie	censee M	014	43	22	Name and Addre	on an	llity nd Fune	eral Al				land 21286
	Physician/ Medical		23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	rt fallure. List or (Final	a. OVAI	RIAN	the death. CANC	ER						wson M	ary	Approximate Interval Between Onset and Death
7	Examiner	er	Sequentially list co	enditions,	b. ———		conseque									
00	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit.	ical Examiner	cause. Enter Unde Cause (Uisease or that initiated event resulting in death)	rlying linjury s	С	conseque										
x 68760	ath certificate be attending physici for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12			Birth 2	Fetal	death 3 🗌	Ectopic pregnance	су				23d. Date		,
D. Box	es that the deal signed by the at be detached fo	hysic	1 Tes 2	No No	9 🗆 Unk	nown	time of de	_	Other (specify)					Mont	.h	Day Year
'ds, P.O.	requires that been signed should be de	۾	Part II. Other signit	icant condition	s contributing to c	death but	t not resul	ting in the ur	nderlying cause giv	ven in Pa	rt I.	23e. Did t		_/		the cause of death?
Division of Vital Records,	: The law re cate has bo , page 2 sh	Completed										24a. Was auto perfo		pri	ior to co ath?	opsy findings available ompletion of cause of 2 No
ta	ician: The certificate ector, pag	Be	25. Was case referred examiner?		Hospital;						eath (Check	only one)				
ί	Phys this (2	1 Yes 2		1			R/Outpatient		4 □ 1						W HOSPICE
ion o	To the Hospital or Attending Physiciam: within 24 hours after death. Its certific completed filled in by the funeral director, completed filled in by the funeral director,	Certificate	1 X Natural 2 Accident 3 Suicide	5 Pending Investigs 6 Could no	(Mon	ith, Day,	Year)	8b. Time of injury				8d. Describe I	now inju	iry occurred		
Divis	Hospital or Al 24 hours after (Funeral Directed filled in by		4 Homicide	determin	ed buildi	ing, etc.	(Specify)		et, factory, office			City or Tov	vn, State	e)		al Route Number,
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	only one) 3	Medical Ex	Physician: To the base aminer: On the base lurse Practioner:	sis of exa	amination a	nd/or investi-	gation, in my opinic	n. death	occurred at t	he time date a	and plac	e and due to	o the ca	ause(s) and manner stated
	5 With		29b. Signature and	Ma	IS CAN	P			29c. License	number	192		29d. Da	ate signed (i	Month!	Day, Year) 2010
)			30. Name and address	JONES,		00 D	ULAN	EY VAI	LEY RD.	TIM	ONIUM	, MD 2	1093	3		
	Stat Registra		31. Date filed (Mont	n, Day, Year)	2 2010	h	s Signatur	e A. 16	backs							
DHM	MH 17 Rev 7/20	009														

Holzhauser, George 10-09716 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month **Medical Examiner** 1340 hrs GEORGE J. HOLZHAUSER, December 16, 2010 JR. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4100 Boston Street **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Director Months Days Hours 214-50-0354 1 X M 2 F 57 02/06/1952 NEW) YORK Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f shuw MD HARFORD ABERDEEN death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3758 ALBINO ROAD 21001 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1 X Never Married 2 Married 2 X No 1 Yes h Specify: WHITE imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after nent of Heath and Mental Hygene.
ant: If item 27 is marked uther than "natural", 1 or other trammatic event, the Medical Examiner. 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: ፩ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) AUTO TECHNICIAN 12 AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE J. HOLZHAUSER, SR. TERESA ELIZABETH HERALD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) T. ELIZABETH HOLZHAUSER/MOTHER 3706 HUDSON STREET, BALTIMORE, MD 21224 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State tment c SACRED HEART OF JESUS 12/21/10 BALTIMORE, MD Donation 5 Other Specify 21. Signature of Funeral Service Licenses There's Address of Earling Inc. Funeral Home 700 S. CONKLING STREET, BALTO., MD 21224 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and .IMedical Death Multiple injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED 27,28a-f, per ME g911 1/11/11/ TT attending physician or use as the burial -Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death Year past 12 months? Pregnant at time of death 5 __ Other (Specify) 1 Yes 2 No 9 Unknown the 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Natural subject struck by train Director: d in by the f 5 Pending 1 Yes 2 X No |Fd 12/16/10 |Fd 1:20 pm Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide railroad tracks or Town, State) 4100 Boston Street determined (Specify) Homicide MD Baltimore, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 17, 2010 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Physician/ 1209 Elmer, Hack December 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bayvier Medical Battimore John Hopkins Centr 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 12/08/1926 1 X M 2 □ F Maryland 217-22-6353 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 275 is marked other than "natural", or items 23a or 28a-f sho ther than "natural", or items be notified at ther traumatic event, the Medical Examiner must be notified at 10a, State Director 1 ☐ Yes 2 🕅 No Baltimore Kingsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21087 7507 Bradshaw Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Specify: White If Yes, Give Year or Dates. WW 3 Widowed 4 Divorced II Completed 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) J. Vinton Shafer Co. Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Theresa Marie Maenert Henry Theodore Hack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7507 Bradshaw Road - Kingsville, Maryland 21087 f Health item 27 Lettie I. Hack (wife) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Air Memorial Gdns. 12/23/2010 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sona un of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. <u> 11750 Belair Road - Kingsville, Maryland</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Subarachnoid hemorrhage disease or condition Medical resulting in death) Examiner hematom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Fall Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 for use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant Day Month in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by Afib, history of stock, hypertension, diabetes, history 2 No 3 □ Probably 4 □ Unknown 1 🗀 Yes steat placement with plavix use 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: work? 1 ☐ Yes 2 No ☐ Natural 5 Pending 20 00 PM Fall while walking upstairs Nov. 11, 2010 4 hours after death.

uneral Director: A
ed filled in by the fu Investigation 28f. Location (Street and Numb r Rura Route Number, 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide determined Home 7507 Bradshow Rd. Kingsville, MD within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check and the basis of well-dark members to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie RES-000 December 20,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Elder, MD 4940 Avenue Baltimore MD 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 7/2009

Registrar

2 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER Magdalena Bowen Hickman 4:15 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. AGNES HUSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Hours Min Director 217-22-7603 Usual Residence of Decedent 28a-f shov th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 711 Academy Road U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Š 1 Never Married 2 Married 2**X** No Yes Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Insurance Claims Examiner Social Security Adim. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Bowen Mary Anna Kalmbacher permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette Roden/ Niece 1114 Spalding Drive Unit H; Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul Lutheran 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 12-21-2010 Aberdeen, Maryland 4 Donation 5 Other (Specify) Church Cemetery 22. Name and Address of Facility Sterling Ashton Schwab Witzke uneral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 ignature of Funeral Service Line nee painell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final BACTEREMIA Physician disease or condition resulting in death) Medical Examiner NEUMONIA DWYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 HOKMAN, MAGDALLIA IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death 1 ☐ Yes ∠ • 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 No 1 Tyes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Manatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 070917 DECEMBER 17 2010

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

BAJAJ

32. Registrar's Signature

3455 WILKENS AVE.

BALTIMORE 21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:50 PM DOUGLAS NATHANIEL HEATH ecember 16200 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Doctor's Community Hospital Lanham 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, 1 XXM 2 □ F Months Hours Min West Virginia 579-52-3520 70 1940 Yrs Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director notified MD Howard Laurel 1 ☐ Yes 2 🔀 X No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe I ms 23a must be Funeral 9120 Stebbing Way, Unit G 20723 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married 1**XX**Yes 2□No 1957 African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XXX Specify: Specify: Completed 3 Widowed 4 Divorced American Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meagnee. Elementary/Seconday (0-12) College (1-4 or 5+) Analyst Grade Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Vernon Heath Monteria Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darren R. Heath 9120 Stebbing Way, Unit G Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Arundel Crem. 12/22/2010 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 22 Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 21. Signature of Funeral Service Licenses / M00770 20707 23a. Part 1. Enter the dise Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ LONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of): ARDIAC FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner to (or as a consequence oi): ULMONARY Cause (Disease or linjury that initiated events resulting in death) Last the burial-transiattending physician Physician/Medical CELL CARCINOMA OF URINARY BLADDER The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: asn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Day Year Yes 2 No detached 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been sign page 2 should be THE CARCINOMA Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 2 🔀 No Yes 2 No 1 Yes Hospital or Attending Physician: completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No မ 1 Yes 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After t Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I only one) 29b. Signature and title of certifit 29d. Date signed (Month, Day, Year) 2

State Registrar Harbha

31. Date filed (Month, Day, Year)

an

00

DHMH 17 Rev 7/2009

6126 Landover Rd.,

Cheverly, MD.

Thugh Hyawal.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rawat, mD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Villiani Tugirco		1- For State Registrar Certificate		Reg. No).					
Physici yledical Exam		1. Decedent's Name (First, Middle,Last) William Francis Xavier Hugh	nes, Jr.	Date of Death Month Day December 21,		3. Time of Death 0845 hrs				
		4a. Facility Name (if not institution, give street and number) 7902 Allard Court # 102	4b. City, Town, or Location of Glen Burnie	Death 4	tc. County of Death Anne Arundel					
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday)		24Hrs. 8. Date of Birth(MM Min. Oct 16,	//DD/YYYY) 9. Birth Foreign					
nd how any cc.	_	Usual Residence of Decedent 10a. State Anne Arundel 10c. City, Town or Loc Anne Arundel	Glen E	Burnie		10d. Inside City Limits 1 Yes 2 No				
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	10e Street and Number 7902 Allard Ct. #102	10f. Zip Code 210		itizen of What Count U.\$	try? S.A.				
면 등록	by Funeral	1 Never Married 2 Married 1 Yes 2 No No No No No No No No No No No No No	Nas Decedent of Hispanic Origin fres, specify Cuban, Mexican, I Yes 2 No specify: ent's Usual Occupation (Give ki	Puerto Rican, etc.)	14. Race - Americ White, etc. Specify: Kind of Business/In	eto				
1215-0036 Id be filed within 72 hours afte dental Hygiene. aarked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life, DO NOT u Sales	se retired)	Re	etail				
21215-0036 wild be filed within 75 Mental Hygiene. marked other than e event, the Medical	Be Co	17. Father's Name (First, Model am Francis Xavier Hughes Sr.	18.Mother's	Name (First, Middle, Maide Jane	Surname) Anne Garvan					
MD 21 d 2 should lith and Me n 27 is ma	To	19a. Informant's Name/Relationship (Type, Print) Kathleen Hughes Sister 19b. Mail 9 S	ing Address (Street and Numb tuart Dr. Dover, DE 1	er or Rural Route Number, (9901	City or Town, State,	Zip Code)				
Baltimore, MD 2 permit. Pages I and 2 shou Oppartment of Health and M Important: If item 27 is ninjury or other tranmatie.		Burial 2 Cremation 3 Removal from State Crest Lawr Donation 5 Other Specify:	osition (Name of cemetery, other place) 1 Memorial Gardens	Dec 24, 2010	. Location - City or T Marriottsvi	Fown, State				
Balt permit Depart Impor		Will du Baher Day Hazgs		oia Pike Ellicott City,						
Physician /Medical ≟xaminer		23a. Part I. Enter the hisselse, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	r the mode of dying, such as car	diac or respiratory arrest, sh	lock, or heart	Approximate Interval Between Onset and Death				
	Ā	Sequentially list conditions, if any, leading to immediate b								
cuted und transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.								
exe	Medical	UNPENDED AMENDED								
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (Specify)								
, P.O. E	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part		o use contribute to th ✓ No 3 Proba	ne cause of death?				
Records The law requirecte has been page 2 should	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of				
Vital hysician:	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26.Place of Death (Ontact 3 DOA Other 4 1		ence 6 🗸 Other:	Scene				
ision of Attending Pher tector: After the by the funeral		27. Manner of Death 1 Natural 5 Pending PolyNote Day, Year) 2 Accident Investigation Dec 21, 2010 28b. Time of UND Dec 21, 2010 UNKNOW		28d. Describe how in Subject shot self						
Divisipital or At ours after d ours after d filled in by	Certification	3 ✓ Suicide 4 Homicide 6 Could not be determined Could not be determined (Specify) A residence	eet, factory, office building, etc.	28f. Location (Street or Town, State) 7902 Allard Court #		al Route Number, City e, MD				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.								
	Ž	29b. Signature and title of certifier Cour of Hell or v	29c. License number O.C.M.E.		Date signed (Monti cember 21, 201					
2		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 2	21201						
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature								

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For Amend Items 242		Cer	tificate of L	Death	Re	g. No.	10.		. 5
Physici	an	1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day	Year	3. Time o	
/Medic		Amelia Hamilton					December	4 2	010	4:00	P N
Examir	ier	4a. Facility Name (If not institution, give street a	nd number)		•	Location of Death			ty of Death		
		203 Deer Run Lane 5. Social Security Number 6. Sex	7. Age (In yrs. In	act hirthday)	Stevens If Under 1 Year		8 Date of Birth	1 *	Queen Annes 9. Birthplace (State o.		
Funeral Director		159-26-6553 1□M 2			Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb 10,	Year) 1932	Coui	ontry) Sylvan	
_		Usual Residence of Decedent					1200 20,		12 0222		
how	_	10a. State 10b. County	10c. City	y, Town or Lo					1	10d. Inside C	•
8a-f	Director	MD Queen Anne	s	Steve	nsville		1			1 □Yes	-2X
Den Den	ij	10e. Street and Number 203 Deer Run Lane			10f. Zip Code	666	10	ng. Citizen of	USA	ntry?	
IS 23	eral	Lien	s Decedent Ever in U.S	S 13 V			necify Yes or No-		ace - Americ	can Indian	
nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	1 □ Never Married 2 Married 1 □ If Y.	ned Forces?]Yes 2 XNo es, Give ar or Dates:		Vas Decedent of Hi fYes, specify Cuba □Yes 2🏋 No	Specify:	Rican, etc.)	Bla	ack, White, ify: whi	etc.	
atural	edi	15. Decedent's Education			lent's Usual Occup			16b. Kind of I	Business/In	dustry	
A Lange	Completed	(Specify only highest grade comp	leted) lege (1-4or 5+)	(Give life. L	kind of work done o OO NOT use retired	during most of worl ()	king				
giene er tha	ĕ	12	2	t	eacher			ed	lucati	on	
al Hy	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, N				
Ment arkec atic e	2	Gorman William Howar	d				Sue Brow				
l s m		19a. Informant's Name/Relationship (Type. Prin Ralph Hamilton/son	nt)	T.	g Address (Street a			•			
Healt em 2 ther		20a. Method of Disposition	20h Pi		Deer Run			e, MD	2166		
Department of Heal Important: If Item 2 any Injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	from State	emetery, cren	sition (Name of natory or other plac	e) :					
Depart Import any Inj once.		21. Signatur of Funeral Service Licensee	Baltin	nore S	Street						
y physician and wedical stansit transit street burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence to (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or	uence of):	Panci	4 .	can		3	Interval Be Onset and	tween Death ICA
by the attending ached for use a	Physician/Medical	in the past 12 months?	es, outcome of pregna] Live birth 2 ☐ Fetal] Pregnant at time of d] Unknown	death 3	Ectopic pregnancy	у			Pate of delive	*	Year
igned be de	출	Part II. Other significant conditions contributing	ng to death but not resu	ulting in the ur	nderlying cause give	en in Part I.		acco use co			
s peen s	ted						1 L Ye	s 2 No	3 Pro	babiy 4∐	Unkno
has e 2	Completed						24a. Was ar autops perforn 1 □ Yes 2	y	 Were autoprior to codeath? 1 ☐ Yes 	opsy findings ompletion of 2 \Bo	. availa cause
certificate rector, pag	Be	25. Was case referred to medical examiner?					th (Check only on				
this or al dire		1 Yes 2 XNo Hospita	1 Inpatient 2			4 LI Nursing H	ome 5 🛣 Reside			ify)	
vfter Iner	ü		. Date of Injury (Month, Day, Year)	28b. Time of Injury	Worl		28d. Describe ho	e how injury occurred			
deat ctor: y the	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e	Place of Injury - At ho building, etc. (Specify	me, farm, stre		Yes 2 □No	28f. Location (St. City or Town	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 Certifying Physician: (Check only 2 Medical Examiner: O	To the best of my known the basis of examina	wledge, deati	n occurred at the tir	me, date and place	e, and due to the c	ause(s) and	manner as	stated.	(e)
hin 24 the Fi	Medical	one) an	d manner stated.	agri aria/01 III							
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	2	29b. Signature and title of pertifier			29c. Licens	e number	2	9d. Date sign	iea (Month,	, ⊿ay, rear)	
		- WOW			Do	0527	53	12/	7/11	У	
		30. Name and address of person who complete	uffakur	23a) (Type,	Print)	30 m	in st	+10	1	hest	tr
		31. Date filed (Month, Day, Year)	3. Registrar's Signal							216	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Cei	rtificate of Dea		Reg. I	2010	11:00				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			M	ate of Death onth	Day Year	3. Time of Death				
parameter.	Medic	al	Marie M. 4a. Facility Name (if not institution, give street and number)	Hall	4b. City, Town, or Loca			18, 2010	10.35 MM				
	Examin	er	Hospice of the Chesapeake	<u> </u>	Linthicu			Anne Arune	1.1				
Т	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If U	Jnder 24 Hrs. 8. Da	ate of Birth	9. Birth Cour	place (State or Foreign				
	Director		217-05-7433 Usual Residence of Decedent	94 Yrs.		Dec	lonth, Day, Year	1916 Ma	ryland				
	land show	tor	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits				
	Many 28a-	Jirec	Maryland Baltimore 10e. Street and Number	Essex	Liet Ti ou		1		1 Yes 2 XNo				
	ith the 23a or st be	Funeral Director		710	10f. Zip Code		109.	Citizen of What Coul	ntry'?				
	eath v	Fune	1000 Franklin Avenue Apt. 11. Marital Status 12. Was Decedent In Armed Forces?	/ 18 Ever in U.S. 13.	21221 Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify Ye	es or No-	U.S.A. 14. Race - Americ					
36	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married 1 Yes 2 X	No	i res, specify Cubail, Me 1 ☐ Yes 2 🌠 No Sp		eic.)	Black, White,					
21215-0036	hours natura dical E	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Occupation	u na nati net consulcium	16b.	Whi Kind of Business In					
21	hin 72 ne. than "	J L	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or secondary)	5+) Ìife. D	kind of work done during O NOT use retired)			G.					
_	filed within al Hygiene. d other thai event, the N	Be C	11th. Grade 17. Father's Name (First, Middle, Last)		lerical	Mother's Name (First		epartment	Store				
Maryland	l be file lental rked c	뎯	Theodore Elias Gorsc	hboth		Elizabeth		herine	Huhn				
lary	should and M is ma auma		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and N	lumber or Rural Route	e Number, City	or Town, State, Zip	Code)				
	e 1 and 2 should be file of Health and Mental H f item 27 is marked o r other traumatic ever		Elizabeth M. Trebe/Niece	20b. Place of Dispo	l Meadowlari		Balti		21227				
nor	Page 1 anent of the ant. If its ury or of		1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, crei	natory or other place)	Date 12/21/20		Location - City or To altimore	MD				
Baltimore,	permit. Page Department Important: I any injury o		21. Sign xure of Fune al Service Lice	DakLawn C					TID				
8	99 =		M		Charles S. 6224 Easter			more MD	21224				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)									Approximate Interval B. tween nset Death				
٠	Medical		Immediate Cause (Final disease or condition resulting in death) a. PRIMALY LUNS CANCER Due to (or as a consequence of):										
	Examiner	e.	Saque titally list conditions, if any, leading to immediate Due to (or as	a consequence of):									
	ted I Insit	Examine	cause. Enter Underlying Cause (Disease or linjury	a consequence on.									
	ificate be executed g physician and as the burial-transit	EX	that initiated events resulting in death) Last C. Due to (or as	a consequence of):									
8760	ate be ohysici the bu	Medical	d										
	oertific oding p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome					23d. Date of deliv	erv				
Box	Physician: The law requires that the death certi this certificate has been signed by the attendin ral director, page 2 should be detached for use	Physician/N	in the past 12 months? 1 Yes 2 No 1 Live Birth 1 Yes 2 No 2 Halanaura	2 Fetal death 3 time of death 5	Description of the control of the co			Month	Day Year				
P.O. I	at the d		9 Unknown Part II. Other significant conditions contributing to death by	out not resulting in the u	underlying cause given in	Part I. 2	3e Did tobacci	o use contribute to t	he cause of death?				
S, P	v requires the sbeen signers should be d	Completed by	Frebruit VER	et Disea	ne Mrs	ers			bably 4 🗆 Unknown				
ord	aw requasi been 2 shoul	plete	conserver H	east for	hure her	wy 2	4a. Was an autopsy		psy findings available empletion of cause of				
Rec	The law ate has page 2 :	Som	Hyper dens in	-	Ma	us 1	performed?	death?	·				
ital	ıysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?		Other	of Death (Check only o			dan .				
of Vital Records,	Phys rr this e	e: 10	1 ☐ Yes 2 No 1 ☐ Inpati 27. Manner of Death 28a. Date of inju	ent 2 ER/Outpatie	nt 3 □ DOA 4 28c. Injury at	Nursing Home 5	Residence		Propies				
on (anding Ph sath. rr. After thi ne funeral	ficat	1 Natural 5 ☐ Pending (Month, Da 2 ☐ Accident Investigation	y, Year) injury	M work? 1 ☐ Yes	2 🗆 No							
Division	or Atto	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injuding, etc.	ury - At home, farm, str c. (Specify)	eet, factory, office		ocation (Street a ity or Town, Sta	and Number or Rura ite)	I Route Number,				
۵	To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After t completed filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of										
,	the Ho nin 24 I the Full	Medical	(Check 2 Medical Examiner: On the basis of e	xamination and/or inves	tigation, in my opinion, de	ath occurred at the tin	ne, date and pla	ce, and due to the ca	use(s) and manner stated.				
	To the within 2 To the comple		29b. Signature and title of certifier	1 K. ISURTA	29c. License num	ser 49		Date signed (Month,					
			30. Name and address of person who completed cause of o	eath (Item 23a) (Type I	Print)	00/	10	ccenter 1	1,0010				
			V _		w Center Ba	altimore	MD 212	24-6821					
	Stat			ar's Signature	w								

O DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Year JUDSON 28 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death (Alkou MOSPINA CONTER MESTAINSTER Age (In yrs. last birthday)
58 yrs Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Days 213-60-6569 California Director Tan. Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director Carroll Meryland Westminster 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a United States 1130 Singer Drive 21157 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc or Completed by 1 Never Married 2 Married ☐ Yes 2 **XX**No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: White Specify: 3 Widowed 4 XXDivorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disability Examiner Social Security Admin Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
June Metts-Carey id Mental F marked o Sydney David Hankoff t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Hankoff (Sister) 6303 Yorkshire Drive Baltimore, Maryland 21212 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel— 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XX remation 3 Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility

Exams Funeral Chapel & Cremation Servies—Parkville

800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner CHRONIC LYCHMOUTIC Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 욘 1 🔲 Yes 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Regis ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20^{Year}0 Jachimski 7:55 am Shelley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice 5. Social Security Number นักเ If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Pay, Days 1 M 2 X F Hours វី963 MD **Director** 47 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Rosedale Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 u.s.a. <u>6800 Golden Ring Road</u> 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗶 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Nelson W. Gatton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, <u>0</u> Middle River, MD 21220 2204 Southorne Road Department of Health Important: If item 27 any injury or other ti <u>Michael Jachimski/spouse</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/23/2010 woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 22. Name and Address of Facility Maryland Cremation Services 21. Signature of Funeral Service Licensed Orota Marshall Baltimore, MD 21203 P.O. Box 1413 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_ysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 📈 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 (No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 W Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the 1 within 2 To the 6 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State			State	of Mar	ryland	d / Dep	artmer	t of H	lealth	and N	/lental Hy	/gien	e211		160471
			Registrar Certificate Of Death Reg. No.							lo.								
	Physicia	ın/											_	2. Date of De Month		Day Yes	ar	3. Time of Death
	Medic Examin		Rose G. 4a. Facility Name (if			reet and nu	mber)			4h City	Town or	Location	of Death	ecembe		0,2010 lc. County of D		8:59A <u></u>
	A	ei	Stella		, 9						moni		TOT DCA(T)		4	c. County of L		Balto.
1	Funeral		5. Social Security N	umber	6. Sex		7. Age (/	In yrs. las	st birthday)	If Unde			r 24 Hrs.	8. Date of Bi		9.	Birthp	lace (State or Foreign
	Director		218-09-3		1 _	М 2ХД F	9:	3	Yrs.	Months	Days	Hours	Min.	(Month, Da Januar	y $\frac{y}{3}$	1.1917	_{Count} Mar	yland
	nd now	٦	Usual Residence of 10a. State	Decedent 10b. County			1	l0c. City.	Town or Lo	cation							10	Od. Inside City Limits
	arylar a-fs fied	Director	Md.	Ва	lto.	,			Rose									1 ☐ Yes 2 ☐ No
	the Mor 28	اغً	10e. Street and Nun	nber					Rose	10f. Zip	Code				10g. 0	Citizen of What	Coun	
	with s 23a ust b	Funeral	9583 De	vonwoo	d Co	ourt					2	1237				USA		
E	ltems items		11. Marital Status		1	12. Was Dec Armed Fo	edent Eve	er in U.S.		Was Deced	lent of Hi	spanic O	rigin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - A		
	after (", or camir	by	1 Never Marri			1 ☐ Yes If Yes, Gi	2 🔼 No	0		1 Yes						Black, W Specify:	,	nc. Mhite
8:59 a 215-0036	ours a	Completed by	3 XWidowed	15. Decede		Year or D	ates.	T	16a Dece	dent's Usua	d Occup	ation			I dol:			
8 5	72 h an "na Media	шb		cify only high		e completed		_	(Give	kind of wo	k done d		st of work	ing	Ti	Kind of Busine 1 Deco	Moc	ern
212	withir giene er th		Elementary/Seco 12th	onday (U-12)		College (1-4 or 5+)		Book	keepe	r				Mar	nufacto	r	
2010 Ind 21	filed al Hy d oth	o Be	17. Father's Name (First, Middle,	_ast)							18. Mot	her's Nam	e (First, Middle	, Maidei	n Surname)		
yla	Ment Ment narke	욘	Frank Wi									St	ella_	Worsaw	orsl	ki		
1 20, 2010 Maryland 21	shou h and 7 is m traum		19a. informant's Na		hip <i>(Typ</i>	,			l	0	,					or Town, State,	•	,
	and 2 Healt em 2		Lois Meh 20a. Method of Disp				DTR.	20h Pk	958 ace of Dispo			od C		Rosed Date		Md. 2		
no P	age 1 ent of it: If it		1 🗆 Burial 2	☐ Cremation				ce	metery, crei	natory or o	ther plac	· :		3-2010		lto. Md		WII, State
DECEMBER Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 21. Signature of Fur				omen	L Va					-			eral Ho		
m m	permit Depar Impor any in	2	Bei	an C	2 1	uel	ع	بعر								n. Md.		36
			23a. Part 1. Enter t shock, or hear	he disease, or	compli	cations that	caused th	ne death.								.,		Approximate Interval Between
Acres	h, sician/		Immediate Cause (Final	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			VF B	EART	FATTE	DE							Onset and Death
	Medical Examiner		resulting in death)		r°		(or as a c										T	
		le l	Sequentially list co	nditions,	b	7900.60	(Ur as a c		wet w								+	
	ed	Examiner	if any, leading to in cause. Enter Under Cause (Disease or	rlying iiniury		- Due to	(or as a c	o Boque	silos vij.									
	xecut n and al-trar	Exa	that initiated events resulting in death) I	3	C	Due to	(or as a c	onseque	ence of):								+	
09	cate be executed physician and s the burial-transit	dical			L.													
	that the death certificate be executed ned by the attending physician and edetached for use as the burial-transi	Med	IF FEMALE:							-								
Box 687	th cer tendii or use	ian/	23b. Was decedent in the past 12 r		23		Birth 2	☐ Fetal	death 3			у			1	23d. Date of		,
	e deal the at hed fo	ysic	1 Yes 2 1 9 Unknown	No		4 ☐ Preg 9 ☐ Unk		me of de	eath 5 L	Other (sp	ecify)					Month		Day Year
P.O.	at the	Completed by Physician/Me	Part II. Other signif	icant condition	ons con	tributing to a	death but	not resu	Iting in the u	underlying o	ause giv	en in Par	t 1.	23e. Did 1	tobacco	use contribute	e to the	e cause of death?
	ires the signer of the signer	d b												1 🗆	Yes 2	2 X No 3 [Prob	ably 4 🗆 Unknown
NO:	v requ	Sete												24a. Was	an	24b. Were	autop	sy findings available
JOHNSON al Record	he lav te has age 2	l lie												auto perfe 1 🗌 Yes	psy orm <u>ed</u> ?	prior death	1?	pletion of cause of
JO al F	ian: T rtifica ctor, p	Be C	25. Was case referre	ed to medical							26. Pla	ace of De	ath (Check	only one)	2 A . I	NO I	165	2 - 110
ROSE of Vit	hysic nis ce I direc	유	1 🗌 Yes 2 🕽		Ho	ospital:	Inpatient	2 🗆 E	R/Outpatie	nt 3 🗆 D	Othe	r: 4 🗆 N	lursing Ho	me 5 Resi	dence	6 X Other (S)	ecify)	HOSPICE
RO	or Attending Physician: The law requires after death. Director: After this certificate has been sign in by the funeral director, page 2 should be	Certificate:	 Manner of Death Matural 	i 5 ☐ Pendii	ng	28a. Date (Mor	of injury oth, Day, Y		28b. Time of injury		8c. Injury work	?		28d. Describe	how inju	ary occurred		
io	death death stor: / the f	tific	2 Accident 3 Suicide	Investi 6 🗌 Could	not be	28a Diace	of Injuny	- At hon	ne, farm, str	M eet facton		Yes 2	-	Of Lastin /	C44	m of \$4	D	Davida Alexandras
ROSE JOHNSON Division of Vital Records,	l or A after Direc		4 L Homicide	determ	ined		ing, etc. (\$		ile, iaitii, su	eet, factory	, onice			City or To		nd Number or e)	rurai i	Houte Number,
В	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Medical		Medical E	xamine	r: On the ba	sis of exar	mination	and/or inves	tigation, in	ny opinio	n, death o	occurred at	the time, date	and plac		ne cau	se(s) and manner stated
	To the within To the complex		only one) 3 29b. Signature and		-	rractioner:	to the be	st of my	knowledge,		red at the License		te and plac	e, and due to th		e(s) and manner ate signed (Mo		
	- > - 0		•	141	10	20 0	PAG				RIU	19-	192	-		12/20	17	2010
	7		30. Name and add	ess of person	who cor	mpleted cau	se of deat	th (Item 2	23a) (Type, F	Print)	')' {	- ('			/	-1-	/	-, -
4_	-		JACKIE		CRN				EY VA	LLEY	RD.	TIM	ONIUM	1, MD 2	1093	3		
	Stat Registra		31. Date filed (Montl	n, Day, Year)	0.00	32. F	Registrar's	Signatu			,							
DHI	MH 17 Rev 7/20		<u> </u>	ULL Z	2 4		Crear.	-	1. A	ala								

DHMH 17 Rev 1/2001

10-09406 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Tashanna Danyel Jones 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 7, 2010 Medical Examiner 1147 hrs Tashanna Danvel Jones 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore County** Franklin Square Hospital Rosedale 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or **Funeral** UNK Months Davs Hours Director Country) 1 M 2 F 8-21-1965 MD 45 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1X XYes 2 No MD Balto Parkville permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Director 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code 8401 Hallmark Circle 21234 USA Funeral 14 Race - American Indian Black 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes Black If Yes, Give Year or Dates: 4 X Divorced 1 Yes 2 No specify. 3 Widowed ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) unk unk Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12th grade 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charlie Rich Valerie P. McMillion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ Tyesha Willis-Daughter Hallmark Circle Parkville, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State crematory or other place) Greenmount 12-16-10 Balto, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 23a, Part I. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Acute Bronchopneumonia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tran Physician/Medical AMENDED item 23a, part II&27 eg 1/18/2011 G911 per ME X UNPENDED attending physician or use as the burial Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 V Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 Yes 2 No 3 Probably 4 V Unknown Cirrhosis of Liver Completed of Vital Records, s been s 24a. Was an 24b. Were autopsy findings available Hypertensive Cardiovascular Disease autopsy prior to completion of cause of certificate has performed? death? page 1 ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: this 1 🗸 Yes No After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Division 1 Yes 2 No the 2 ___ Accident in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City 3 Suici

Hospital or Attending Physician: within 24 hours after To the Funeral Dire filled completely

Sa

State

Registrar

3 Suicide 6 Could not be		- · · · · · · · · · · · · · · · · · · ·	or Town, State)
4 Homicide determined	(Specify)		
	To the best of my knowledge, death occurred a		
	n the basis of examination and/or investigation, d manner stated.	in my opinion, death occurred	at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)
in his.		O.C.M.E.	December 8, 2010
30. Name and address of person who com	pleted cause of death (Item 23a)		
Ling Li, MD Assistant Med	ical Examiner 111 Penn Street, E	Baltimore, MD 21201	
31. Date filed (Month, Day, Year)	32. Registrar's Signature		

parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:00a^M RONALD С. **JAMES** 2010 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death RANDALLSTOWN BALTIMORE CO NORTHWEST HOSPICE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea MAR 21 1 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Days Months Hours Min. Country) MARYLAND Director 214-26-1333 78 MAR. Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3701 LIBERT HEIGHTS AVENUE 21215 U.S.A. death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give "natural", or 1XXNever Married 2 Married ð 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) Callege (1-4 or 5+) 12vrs BALTIMORE CITY HUMAN SERVICES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be ALBERT E JAMES BEATRICE PLANTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bartwood Rd., Baltimore, Maryland 21215 Wendy James Johnson/Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 permit. Page 1 a Department of H Important: If ite any injury or ot 1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-23-2010 KING MEMORIAL PARK BALTIMORE, MARYLAND . Signature peral Service 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ea # line Immediate Cause (Final Mullet Physician/ disease or condition whi Medical resulting in death) a a consequence Examiner neuminer 15/4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown detached P.O. cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Hame 5 Residence 6 Other (Specify) 1 Yes 2 1 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death Investigation 6 Could not be Accident within 24 hours after deat

To the Funeral Director:
completed filled in by the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) flype, Print 3017 € 203 32. Registrar's Signature

0043375

29d. Date signed (Month, Day, Year)

2010

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5060M Dorothy Dolores Johnson 2010 Medical 4a. Facility Name (if not institution, give street and nun or Location of Death Examiner 4b. City, Town, 4c. County of Death altimore osedale Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 214-30-5943 1 - M 2 XF Hours Min willer 13, 1932 Maryland Month: Director 78 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore MD 1 Yes 2 No 10e. Street and Number 10f, Zip Code ö 10g. Citizen of What Country? iral", or items 23a o Examiner must be 21234 Funeral 2416 Woodcroft Road USA death \ 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc ģ 1 Never Married 2 Married Yes "natural", or Baltimore, Maryland 21215-0036 hours after 1 Yes 2 No Specify: white If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired)
Administrative Assistant Monumental Life permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany once. Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Catherine H. Kurtz Walter E. Meineke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 21234 2416 Woodcroft Road-Parkville, Maryland Walter Johnson, Jr-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Dec. 23,2010 Parkville, Maryland Parkville Cemetery 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee Evans Funeral Chapel and Cremation Ser. 8800 Harford Road-Parkville, MD 21234 Me Feed 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. uo cardia arction disease or condition Medical resulting in death) Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a conse that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death sate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law autopsy this certificate 1 Yes 2 No 2 No Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ပ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA . Manner of Death 28a. Date of injury (Month, Day, Year) Division of 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After iniury 1 Matural 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical LEcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year) William Undrew 12-18-2010 1237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar William H. K 31. Date filed (Month, Day, Year,

Donothe

Tohnson

32. Registrar's Signature

			Please 7	TYPE OF Printing State of Manya	Black Indel	ible In ent of I	k. Ensure Health and	All Copie Mental Hy	es Are Legible rgiene	e.
			State Registrar Decedent's Name (First, Middle, Last)			ate of I	Death	2. Date of De		3. Time of Death
	Physicia Medic		RICHARD L	HETOR KA	2CHA			Decen		10 7:10 PM
	Examir	er	4a. Facility Name (if not institution, gives Loure Region 5. Social Security Number 6. Sex	al Hospital		L	aurel			George's
	Funeral Director		191 28 4925 19	M 2 □ F 7. Age (In yrs. 7.	Yrs. Monti	hs Days	If Under 24 Hrs Hours Min.	8. Date of Bi	9. Eq., Year) 1935	Birthplace (State or Foreign Country)
	yland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County	,	ity, Town or Location					10d. Inside City Limits
	he Mar or 28a- e notifi	Director	MO PRINCE C	SECRES !	LAUREL 10F.	Zip Code			10g. Citizen of What	1 X Yes 2 ☐ No
	h with t ns 23a must be	Funeral	15505 BOU.	NOS AVEN	NE		10707		US	A
9	within 72 hours after death with the Maryland igene. ier than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 No 19 If Yes, Give	If Voc c	pecify Cuba	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian, nite, etc.
21215-0036	ours afl atural", cal Exa		3 X Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates.	62	- 11	Specify:		Specify:	WHITE
215	nin 72 h ne. han "na e Media	Completed	(Specify only highest grad		ife. DO NOT	work done (use retired)	during most of wor	king	16b. Kind of Busines	
d 21	lled with Hygier other t ent, th	Be	17. Father's Name (First, Middle, Last)	4	ENG	INEE		ne (Firet Middle		ELECTRIC
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health am Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ပ္	UNKNOWA		en Krcha		Josphin	JENOU	Maiden Surrame go	
	and 2 shou Health and em 27 is n		19a. Informant's Name/Relationship (Typ) WILLIAM COSTA	e, Print) DW/FRIEND			and Number or Ru		er, City or Town, State, .	- 771
Baltimore,	0 <u></u>		20a. Method of Disposition 1 Burial 2 Cremation 3 F	20b.	Place of Disposition (N	vame of or other place	ce)	Date	20c. Location - City	or Town, State
Ħ H	permit. Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	- $ SP $	21NG-ITELN 22 Name				SYFESULL NUEH &ME	
ä	Dep Imp any onc	b	Jeff N. Zumb.	run	60,26	SYFE	-SVILLE R	N ELDE	as BURG-M	021784
	าเงราะเอก/		23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only one Immediate Cause (Final	cations that caused the dea cause on each line.	th. Do not enter the m	ode of dyin	ig, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	Ince of):	IN.	\			
		ner	Sequentially list conditions, but any, leading to immediate	Due to (or as a conseq	The second second	Co	n hus,)			
ď	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	ulance off:					
0	e be ex ysician ie burial	=	d d							
68760	death certificate be ne attending physici ed for use as the bu	/Мес	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna	ancv					
Box	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medica	1 Yes 2 No	1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 Ectop		су		23d. Date of o	Day Year
P.O.	law requires that the tas been signed by the 2 should be detache	by Ph	Part II. Other significant conditions con	ributing to death but not res	sulting in the underlyin	g cause giv	ven in Part I.		obacco use contribute	
rds,	requires been sig	eted								Probably 4 Unknown
Vital Records,	Physician: The law this certificate has tral director, page 2 s	Completed						24a. Was auto perfo 1 Yes	psy prior to ormed? prior to death?	autopsy findings available completion of cause of ? Yes 2 No
ta	ician: I sertifica ector, p	Be	25. Was case referred to medical examiner?	espital:			ace of Death (Chec		2 2 10 1 1 1	es 2 tano
ot v	g Phys er this eral dir	te: To	27. Manner of Death	1 Impatient 2 28a. Date of injury (Month, Day, Year)	ER/Outpatient 3 28b. Time of	28c. Injury	4 □ Nursing H y at		dence 6 Other (Spenow injury occurred	ecify)
nois	ttendin death. stor: Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		injury M		Yes 2 No			
Division of	or the rospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director, i		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	v)			City or Tox		
:	n 24 hor n 24 hor ne Fune	Medical	(Ch/eck 2 Medical Examine	ian: To the best of my know r: On the basis of examinatio Practioner: To the best of m	n and/or investigation,	in my opinic	on, death occurred a	at the time, date a	and place, and due to the	e cause(s) and manner stated.
	vithi To th	-	29b. Signature and title of certifier			9c. License	number		29d. Date signed (Mon	
,	1 1 1	\	30. Name and address of person who cor	npleted cause of death (Item	n 23a) (Type, Print)	100	067219		n Dusen 1	Road
	∖ ∖ √ Stat	e\ e	Rohit Khirbat, N 31. Date filed (Month, Day, Year)	D Laure 32. Registrar's Signa	Regional	Hosp	ital L	aurel,	MD 2	0707
	Registra	_	DEC 0 0 2010 6	14 ha	1.8					

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Barbara C. Kelly 11:15A^M Dec. 18 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Meridian Ctr. Dunda1k Baltimore Co. 8. Date of Birth (Month, Day, Year)
July 9,1933 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 F Months Days Hours Director Pennsylvania 213-28-4702 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be positive once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** 1 ☐Yes 2X No Dundalk MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 1928 Cedar Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Be Completed by Specify 3€XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Powell Harper Campbell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1928 Cedar Lane Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type. Print) William D. Kelly, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 12/22/2010 Baltimore, Maryland 21. Signature of Fuperal Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. 7922 Wise Ave. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed 10 NAR Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) □Yes Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 Unknown 1 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ∐Yes 2 ∐No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending investigation death. 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

22 2010

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM# 9perFH, G913, 3/14/2011, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kraemer Nina Grace Physician/ Month 2010 9:00 A M Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Severna Park Kris-Leigh Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🏋 F Months Days Hours Min July 24, 1928 Country)
West Virginia Yrs Director 212-26-0669 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified or once. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Severna Park Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 United States Rom 107 831 Richie Hwy. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Yes 2X No Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 ₺ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 11 Years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nina G. Roach Alvin B. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Jean Baker (Daughter) 3113 Shrewsbury Lane Riva, Maryland 21140 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/20/2010 Baltimore, Maryland Lawn Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 226. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition drome Medical Examiner resulting in death) pr as a consequence of ASOL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events and (or as a conse quence of resulting in death) Last attending physician for use as the buria Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à page 2 should be 2 No 3 Probably 4 Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe death? 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 X No Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA After this Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No M Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law 24 hours after death Funeral Director: within 2

> 30. Name and address of person who completed ause of death (Item 23a) (Type, Print)
>
> 888 Best garde Annapolis, 0 31. Date filed (Month, Day, 32. Registrar's Sign State 2 2 Registrar

Medical

29a. Certifier (Check

only one

29b. Signature and title of certifier

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2010

21114

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:00 AM Theresa Marie Kelly 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 4015 - 2nd Street N/A Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 09/26/1930 Days Hours Min. 1 M 2 XF Months Maryland Director 212 26 0563 80 Usual Residence of Decedent show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 5.0 or 12 is marked outher than "natural", or items 5.0 or 12 is marked outher than "natural", or items 5.0 or 12 is marked as 1.0 or 12 is mark 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 🕱 Yes 2 🗌 No Maryland 10e. Street and Number 10f. Zip Code ems 23a or r must be r 10g. Citizen of What Country? Funeral 21225 4015 -2nd Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Ş 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 XWidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Nursing Home Administrator vears Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Stanley Kolodziejski Catherine Knach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4015 - 2nd Street Sharon Manby / Daughter Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 12/21/2010 Crownsville, Maryland State Veteran Cemi 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. crome Ritchie Highway Baltimore, Maryland 21225 4001 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner (6h(01/100) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated page 1997). Examine en (ulrow Hospital or Attending Physician: The law equires that the death certificate be executed as the burial-transit (6, and that initiated events resulting in death) Last Due to (or as a consequence of) After this certificat, has I een signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 2 🗌 No 1 TYes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: ျှ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) Certificate: 27. Mar r of Death 28b. Time of 28c. Injury at 5 Pending injury Natural work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation the 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying fluxse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check within 2 only one 29b. Signature and title of q 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

ester

てい

31. Date filed (Month, Day)

MD

32. Registrar's Signature

Brocklyn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Day eed love anne 3010 Medical December 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Arunde Anne Burnic Baltimore washing ton Medical center 6101 If Under If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Germany Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🛣 F Months Days 74 September 1, 1936 Yrs 519-48-0962 Director Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🗓 No Mary1and Anne Arundel Severn o 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 356 Council Oak Drive 21144 United States 12. Was Decedent Ever in U.S. 11, Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 X No "natural", or Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Divorced 4 Divorced eedy, Honnelone 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Microbiologist Food Processing 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Karl Jumel Wilhelmina Vonstreb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. John F. Keedy/Husband 356 Council Oak Drive, Severn, Maryland 21144 Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery
Crownsville 20a. Method of Disposition 20c. Location - City or Town, State Date 1 💹 Burial 2 ☐ Cremation 3 ☐ Removal from State December Crownsville, Maryland 4 Donation 5 Other (Specify) 2010 22. Name and Address of Facility
Donaldson Funeral Home & Crem
1411 Annapolis Road, Odenton, 21. Signature of Funeral Service Ligens & Crematory, P.A. denton, Maryland 21113 ARIE MO1386 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

Stroke Approximate Interval Between inset and Death Ph_sician/ / Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to in reduct cause. Enter Underlying Cause (Disease or iinjury Examiner District for as a nonsequence on been signed by the attending physician and should be detached for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pukemia neumonia 1 Yes 2 No 3 Probably 4 Unknown To the Funeral Director; After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 2 No |은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work' 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,)

Hos

death (Item 23a) (Type, Print)

30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylar	-	artment of tificate of		nd Mental Hy	C1 /1	1 1	1.0481
	Registrar 1. Decedent's Name (First, Middle, Last)							Deam	2. Date of De	Reg. No.	l U	Lo Time of Booth
П	Physician/								Month December	_Day	Year	3. Time of Death 3:15 A
pr. 10	Medic Examin		4a. Facility Name (if not institution,	give street and numb	· · · · · · · · · · · · · · · · · · ·	Сишис	4b. City, Town,	or Location of		4c. County		J.13 A
	,		Locust Lodge Assist	ted Livino			Pasader				Arunde:	1
T	Funeral		5. Social Security Number		. Age (In yrs.		If Under 1 Yea Months Days	r If Under 2			9. Birthp	olace (State or Foreign
	Director		210-22-6658 Usual Residence of Decedent	T L W Z M F	80	Yrs.	Wientalio 2 ay	1.104.10	Nov. 29,	1930	Penns	ylvania
	nd how at	ក	10a. State 10b. County		10c. Ci	ty, Town or Lo	ation				1	Od. Inside City Limits
	laryla 3a-f s tified	Director	Maryland Anne Ari	undel	Seve	rn						1 🗌 Yes 2 🚻 No
	or 2		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	s 23s	Funeral	1706 Angel Court				21144			U.S.A.		
	death r item ner n	Fui	11. Marital Status	12. Was Decede Armed Forc	es ? /	S. 13. V	Vas Decedent of Yes, specify Cul	Hispanic Origi pan, Mexican,	n? (Specify Yes or No- Puerto Rica <i>n</i> , etc.)		ce - Americ ck, White,	
36	al", o	d by	1 ☐ Never Married 2 ☐ Marr 3 🗶 Widowed 4 ☐ Divorced	ried 1 Yes 2 If Yes, Give Year or Date		1	☐ Yes 2 🖁 N	o Specify:		Specify	White	e
9	hours natur ical E	Completed	15. Deceder	nt's Education		16a. Deced	ent's Usual Occu	pation		16b. Kind of B	lusiness Inc	dustry
218	in 72 e. nan "ı	dmc	(Specify only highe Elementary/Seconday (0-12)	st grade completed) College (1-4	or 5+)	(Give I life. D	ind of work done NOT use retired	e during most (d)	of working			
2	y with ygien her th	Be C	12	N/A		Homen	aker	T		Own Ho		
Maryland 21215-0036	ntal Herental To B	17. Father's Name (First, Middle, L	ast)		C± amum	ı		's Name <i>(First, Middl</i> e,	Maiden Surnam	•	aloney	
ž	d Mel d Mel mark matic	ľ	William 19a. Informant's Name/Relationsh	nin (Time Print)		Sigmun		Mary	or Rural Route Numbe	on City on Town		-
Ma	I 2 shouth and the sh	â	Ann K. Witt (Daught			11	-		, Maryland 21	· -	state, zip C	5000)
ē,	1 and if Hea item othe		20a. Method of Disposition			Place of Dispo	sition (Name of patory or other pla		Date	20c. Location	- City or To	own, State
E	Page nent c ant: If ary or		1 A Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ∐ Removal from S pecify)		11side C		12	2/28/2010	Roslyn,	Pennsy:	lvania
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee		Mc 22	. Name and Addi Cully—Poly	ess of Facility niak Fur	neral Home, P	.A.		
	_	Н	23a. Part 1. Enter the disease, or	complications that cal	used the deat	132 th. Do not e <i>n</i> te	Y Mountain the mode of dy	n Road I ing, such as ca	Pasadena, Mar ardiac or respiratory ar	yland 211: rest,	22	Approximate
8	Pnysician/ Medical	8 V	Shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a.	ar Kin	Sohl	Λ	sease				Interval Between
	Examiner			Due it (or	as a conseq	uence of):						
	ed	dical Examiner	Sequentially list conditions, if any leading to himself to cause. Enter Underlying Cause (Disease or liniury	Due to (br	ds a cursiq	uente or					-	
	aath certificate be executed attending physician and for use as the burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or	as a conseq	uence of):						
00	e be e ysicia e buri	ical	1	d								
6876	tificat ng ph as th		IF FEMALE:	T								
9 X	th cer ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?		rth 2 🗌 Fet	al death 3 🗆	Ectopic pregna	ncy			ate of delive	ery Day Year
Box	es that the dea signed by the a be detached f	ysic	1 Yes 2 No 9 U <i>n</i> known	9 Unkno	int at time of wn	death 5 L	Other (specify)				511(11	
P.O.	that the ned by a deta	y PI	Part II. Other significant condition	ns contributing to dea	th but not res	sulting in the u	nderlyi <i>n</i> g cause (given in Part I.	23e. Did t	obacco use co <i>n</i> l	tribute to th	ne cause of death?
ds,	requires been sig should b	ted t							1 🗆	Yes 2 No	3 🗌 Prot	bably 4 Unknown
Division of Vital Records,	law requi	Completed by Physician/Me							24a. Was	psy	Were autor prior to cor death?	psy findings available mpletion of cause of
Be	rsician: The law r s certificate has k lirector, page 2 s		OF Management and the second and						1 🗌 Yes		1 Yes	2 No
/ital	siciar certif irecto) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		LED/O. ++:	_ 0+	her	(Check only one)		/O :/	Austol
of \	g Phy er this eral d	e: To	27. Manner of Death	28a. Date of	injury	ER/Outpatien 28b. Time of	28c. inju	ıry at	sing Home 5 Resi 28d. Describe I	now injury occur		LIVING
on	ath. r: Afte	icat	1 Natural 5 ☐ Pendin 2 ☐ Accident Investig	gation	Day, Year)	injury		rk? ☐Yes 2☐N	No			0
Visi	or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determi	incd 28e. Place of	f Injury - At he	ome, farm, stre	et, factory, office		28f. Location (City or Tov	Street and Numb	er or Rural	Route Number,
Ö	pital c		On O I'm A Months	Division Table has	A of l	1						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical E	xaminer: On the basis	of examination	n and/or invest	igation, in my opir	nion, death occ	ace, and due to the ca surred at the time, date a and place, and due to th	and place, and du	e to the cau	use(s) and manner stated.
	To t To t		29b. Signature and title of certifier	Streta	l		29c. Licen	se <i>n</i> umber	4	29d. Date signe	d (Month, I	Day, Year)
			30. Name and address of person	who completed cause	of death (Iten	n 23a) (Type, P	rint)	1	FA	C1 10	7	112001
			L110tt G	10th alyon	0, 1	11/	Madila	lar	- Drug	Olon To	TALP	me 1106
	Stat		31. Date filed (Month, Day, Year)	\$2. Reg	jistrar's Signa	tarkel			(
	-		11-1. 2 2. 7.110	- Ballion		200						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12 Month Day Walter Lawrence LeFave 9:04 am 14 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Marys Hospice House Callaway Marys If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1X M 2 🗆 (Month, Day, 10/5/ 60 **Director** 010-42-9168 1950 MA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director MD 1 Yes 2 No Hollywood St. Marys 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 26332 Cherry Lane 20636 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 □ No If Yes, Give 73–93 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates White th and Mental Hygiene. 27 is marked other than "natun traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Navy/Gemini Aircar 5+ Pilot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter W. LeFave Ruth McIsaac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Pamela L. LeFave (Wife Cherry Lane, Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12/20/10 4 X Donation 5 Other (Specify) MedCure Orlando, FL 21. Signature of Fun al Service Licensee 22. Name and Address of Facility 8018 Sunport Drive MedCure Orlando, FL 32809 23a. Part 1. Enter the Visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 4 Ponset and Death Immediate Cause (Final Physician/ METASTATIC GASTROESOPHAGEAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 9 Unknown q | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ₺ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) HOSPICE House 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Pending 1 Yes 2 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) HOSPITAL 25500 TOINI 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar
DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29c, per DVR, G910, 12/22/10 TT State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** eahas /Medical OG TACHYRADS 9010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** | Honder 1 Year | Honder 24 Hrs. | 8. Date of Birth (Month), Days | Hours | Min. | 05/26/1986 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F N/A 24 United Kingdom Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State United 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Kingdom Kent. Bexley 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 142 Murchison Avenue DA53LL United Kingdom Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cosmetology Hair Stylist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kevin Burke Breege Ann Lanfear ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Breege Ann Lanfear / Mother 142 Murchison Avenue Bexley, UK DA53LL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, Woolwich Cemetery 01/05/2011 Plumstead, London, UK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service e Licensee 401 S. Chester Street Baltimore, Maryland 21231 23a. Fart . Enter the disease, Complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) SITAMUA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any local cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed MEDICAL EXAM Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical CERTIFICATION APP IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 🕽 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗌 No 1 Inpatient 4 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation After 1 Natural 06:00 MOTOR BIKE ACCIDENT eral Director; Af /16/2010 1 Yes death. 2 Accident M 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

BERMUDA determined 4 Homicide OUT OF COUNTRY - BERMUDA within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 **RES000** December 20 2010 who cometed cause of death (Item 23a) (Type, Print) ARNAB 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State Registrar

within 24

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated.

HONDER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number RES

29d. Date signed (Month, Day, Year)

3001 S. HORGIER St. Baltimore, MD

DECEMBE 20: 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lucinda Month 12 McNeill aм 2010 11:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1834 N. Caroline Street Balto Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8 – 29 – 1942 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Hours Min. 212-42-9739 MD Director 68 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director notified 28a-f Y Yes 2 ☐ No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 21213 USA 1834 N Caroline Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc ö þ 1 Never Married 2 Married 1 Yes If Yes, Give 2X No 21215-0036 1 ☐ Yes 2 XNo Specify: Black Specify: "natural" Completed 3 X Widowed 4 □ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Child Care Provider years Self Employed Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Nellie Monroe Joseph Francis Monroe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth McNeill-Son 1834 N. Caroline Street Balto, MD 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 12-17-2010 4 Donation 5 Other (Specify) King Memorial Randallstown, MD 22. Name and Address of Facility 21. Sign Funeral Service Licen see March East F/H ture Balto, 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart rejure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. 5101 disease or condition Medical resulting in death) D e o (as a consequence of) Examiner Disease Nyn Sequentially list conditions, ine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequal ce of): Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months
1 Yes 2 100 Day Pregnant at time of death 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 7 K 2 No 1 Yes _ Yes To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 \square Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

Registrar DHMH 17 Rev 7/2009

State

only one)

JULIE

31. Date filed (Month, Day, DEC 22 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mar

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

790EU (10t

29d. Date signed (Month. Day. Year)

12/10/0

5760/Loch Raven Blud

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20 Physician/ Month 55P Andrew Charles Mayer 2010 Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2 □ F Months Days Hours Min (Month, Day, Year) Yrs Director 104-20-0039 06/13/1927 NY Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Me Iteal Examiner must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4925 Battery Lane Apt. 804 20814 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1944-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Attorney US Government permit. Page 1 and 2 should be filed wirt Department of Health and Mental Hygien Important: If item 27 is marked other ti any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Mayer Jane Rosenheim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Mayer/Wife 4925 Battery Lane Apt. 804 Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Dec.Da22, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2010 Beltsville, MD Chesapeake Crem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FaciliRapp Funeral & Cremation Services MO1585 Rebo 933 Gist Ave. Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute Renal Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): this certificate has been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year Yes be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier LX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature ar 29c. License numbe 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed quise of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Natasha Hagg

8600

014

32. Régistrar's

MAURI

Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month DFC WILLIAM J. McGRAW SR. 6:30P M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 11701 Hamilton Place White Marsh Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Maryland XX M 2 D F Min (Month, Day, Hours Director 212-03-9691 90 Ĺ920 Nov Usual Residence of Decedent or 28a-f show notified at show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 Yes 🗶 💭 No 10e. Street and Number 10f. Zip Code ö 10g, Citizen of What Country? "natural", or items 23a or Funeral 21206 USA 7 Belinda Avenue 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2X No Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: SpecifiWhite 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Murray Steaks Co Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Joseph Patrick McGraw Elizabeth Mary Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11701 Hamilton Place White Marsh, Md. 21162 Betty Woolfenden (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gardens of Faith 12-20-2010 Baltimore, Md. 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Lassahn Funeral Home
7401 Belair Rd. Baltimore, Lassaln 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ myocardial disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury that is interested to the cause of the Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LUNG Cancer 1 Yes 2 No 3 Probably 4 Unknown peen 14 palipemo 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 this certificate has 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) daughin 1 Tyes 2 **N**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: After 1 X Natural iniury 5 Pending Accident
Suicide Investigation within 24 hours after deatl To the Funeral Director. completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marken D16189

Registrar
DHMH 17 Rev 7/2009

6701 N Charles St 44202 TOWSON MD 212 Gy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) DEC 2 2 2010

KARKARMO

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10 State of Maryland / Department of Health and Mental Hygiene

			1. For State Crivial yland / Department of Freatth Certificate of Death Registrar	70	$_{Reg.No.}$ 2010 \downarrow 0 \downarrow 93
	Physici dical Exam		Decedent's Name (First, Middle,Last)	2. Date of De	ath 3. Time of Death
Me	dicai Exam	ner	Edward Scott Meadows 4a. Facility Name (if not institution, give street and number) 4b. City. Town	December, or Location of Death	Day Year er 15, 2010 1909 hrs
4			Baltimore Washington Medical Center Glen Bul		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		irth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
	Director		218-08-9337 1XM 2 F 26 Yrs.	Days Hours Min. 01/	16/1984 MD
	iny		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	nd show a	_	Maryland Anne Arundel	Severn	1 Yes 2 X No
	Aarylau 28a-f	Director	10e. Street and Number 10f. Zip Coo	de	10g. Citizen of What Country?
	vith the Maryland s 23a or 28a-f show e notified at unce.	Ö	8092 Quarterfield Road	21144	USA
(ath wit tems 2	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cu	f Hispanic Origin? (Specify Yes or N uban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
\	fler de	/ Fu	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X	No specify:	Specify: White
	ours al	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occ	upation (Give kind of work done	16b. Kind of Business/Industry
	36 n 72 h ical E	olete	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT use retired)	
	J withi	Completed	11 Construct 17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,	Self -employed
	215 be filed tral Hy tked of	Be C	Larry M. Meadows	Janet John	·
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", ur items 23a or 28a-f sho injury nr uther traumatic event, the Medical Examiner must be notified at nace.	P		Street and Number or Rural Route Nu	umber, City or Town, State, Zip Code)
	nd 2 staith ar		Larry M. Meadows (father) 8092 Quarte 20a. Method of Disposition 20b. Place of Disposition (Name o	erfield Road, Seve	ern, MD 21144 20c. Location - City or Town, State
	Baltimore, permit. Pages I ar Oppartment of Hes Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	Dec. 21	200. Edication - City of Town, State
	Itim ii. Pa artmen ortant		4 Donation 5 Other Specify: Glen Haven Cemer 21. Sign ture of Funeral Service Denses 22. Name and Add		Glen Burnie, Maryland
	Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep		11) 4 # . 1	Stalling Stalling Stalling	gs Funeral Home, P.A. sadena, MD 21122
	Physician		23a. Part I. Enter the disease, or complications that daysed the death. Do not enter the mode of dy failure. List only one cause on each line.	ring, such as cardiac or respiratory ar	rrest, shock, or heart Approximate Interval Between Onset and
	/Medical xaminer		Immediate Cause (Final disease a. Alcohol and narcotic (hero	oin) intoxication	
			2 de 10 (de de de 001100 de).		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
	ال	Examiner	CDisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
	ecuted and transi		d		,
	certificate be executed anding physician and see as the burial - transi	Medical	X UNPENDED AMENDED 23a, 27, 28a-f, per ME g911	1/18/11 TT	
	876 tificate ng phy		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live high	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
	Box 687 e death certific the attending I ed for use as t	sicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		
	the de	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Part I 23e Did	tobacco use contribute to the cause of death?
	Division of Vital Records, P.O. tal ar Attending Physician: The law requires that the rs after death. **I Director: After this certificate has been signed by led in by the fumeral director, par e 2 should be detach	Ď	contributing to death but not resulting in the distortion and	1 Ye	
	requir	letec		24a. Was	
	eco he law alc has	Completed		auto	ppsy prior to completion of cause of ormed? death? 2 No 1 Ves 2 No
	al R	Be	overines?	lace of Death (Check only one)	
	Physical refries call direction	10 12	1 Ves 2 No Hospital 1 Inpatient 2 V ER/Outpatient 3 DOA		Residence 6 Other:
	ding J		(Month, Day, Year)	Injury at Work? 28d. Describe Yes 2 XNo unk	how injury occurred
	Atten Atten or deat rector	Certification:	Accident Investigation Fd 12/15/10 Fd 6:18 pm 28e Place of Injury - At home farm street factory offi		(Street and Number or Rural Route Number City
	Div	erti	Suicide 4 Homicide 6 X Could not be determined (Specify) (Specify) Tesidence	or Town.	(Street and Number or Rural Route Number, City State) 1116 Sunnybrook Glen Burnie, MD
1)	Husp 24 hoi Fune etely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time	e, date and place, and due to the cau	use(s) and manner as stated.
ات	Division of Vital Records, P.O. Box 68760, In the Huspital ar Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, par e 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	nion, death occurred at the time, date	e and place, and due to the cause(s)
		₹	2	cense number	29d. Date signed (Month, Day, Year)
			Thedore M. King JR. m. D.	.C.M.E.	December 16, 2010
			30 Name and address of person who completed dause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 2120	11
			31. Date filed (Month, Day, Year) 1 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 01.00 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Perianayagam Mariasusai December 03:16 P^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery . Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, 1<u>946</u> 1 🕅 M 2 🗆 F Days Months Hours Director 64 June 577-88-4125 India Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? pe Funeral items 23a 8610 11th Avenue 20903 United States within 72 hours after death "natural", or iten edical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Was Decedon.
Armed Forces?
1 ☐ Yes 2 🏋 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🗓 No Specify: Specify: Asian Indian Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Food Service of Health and Mental Hygie If item 27 is marked other Ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Last Name Savrianmal <u>First Name Not Available</u> Mariasusai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4no. if Health au. ~ 27 ir Mary F. Sudan/Cousin Spring, Maryland 20904 3420 Kilkenny Street, Silver Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition 1 😾 Burlal 2 🗌 Cremation 3 🗎 Removal from State Date 20c. Location - City or Town, State Page 1 a <u>∺</u> ៦ December 20 2010 Important: It any injury or once. Donation 5 - Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will E Hours M00672 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardio Respiratory Arrest Medical Due to (or as a consequence of) Examiner Adult Respiratory Distress Syndrome Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence on attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed' this certificate Yes 2 X No 1 🗌 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🔲 Yes Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Box 68760 P.0. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. Division of Vital within 24 hours after death

To the Funeral Director: A
completed filled in by the f

Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29d. Date signed (Month. Dav. Year) December 9, 2010 leted cause of death (Item 23a) (Type, Print) Maria Tayag, M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year, 32. Registrer's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nó. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7:40 P.M 18, 2010 Margaret White Mentzer December 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Harford 505 Plumtree Road Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 22, Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) Days Months Hours 1 □ M 2 🕅 F 92 215-16-9044 Marvland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 □Yes 2 X No Marvland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 USA 505 Plumtree Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 **X** No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Adelaide Archer Thomas Earl White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Plumtree Road, Bel Air, MD 21015 James C. Mentzer Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Carmel Chapel Cem 12-21-10 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. mus a 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final HEART FAILURE CONGESTIVE disease or condition resulting in death) Due to (or as a consequence of): SCHEMIC CARTONOMYDPATTIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Tyes 2 7No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 【 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ō 23a

items .

ō

'natural",

filed within 7 I Hygiene. other than "n

pe

Pages 1 and 2 should

Health

27

Department of Heall Important: If item 2 any injury or other

h and Mental Hygier 7 is marked other th

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

à

Completed

Be

၉

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

traumatic event, the Medical Examiner must be notified

burial-trar physician the burial nse atter for u signed by the a been si cate has l page 2 s certificate this

After thi funeral of

at or Attending F s after death. I Director: After id in by the funera

To the Hosping.
within 24 hours after
To the Funeral Dir

Box 68760.

o.

۵.

of Vital Records,

Division

9 Unknown

25. Was case referred to medical examiner?

5 Pending investigation 1 Natural 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

29c. License number D\$5 W7

DECEMBER IN LOW

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh

ABHYANKAC I NORTH AVE BEZ AIR MAKUL

State Registrar 31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician (Color Examino) To Section Name First MailSocked? To Feeling Name From Institution, government and nember) To Feeling Name From Institution, government and nember) To Feeling Name From Institution, government and nember) To Feeling Name From Institution, government and nember) To Feeling Name From Institution, government and nember) To Feeling Name From Institution, government and nember) To Feeling Name From Institution, government and nember) To Feeling Name From Institution, government and nember) To Feeling Name From Institution, government and nember) To Feeling Name From Institution, government and nember of property in the property of			Registrar		Cen	tificate c	of Deatr	7			Re	eg. No.				
Turned Director Turned	Physici	an/														
Turned Director Turned	Adical Exam	cal Examiner Roger Mayle						II					December 20, 2010			
Laure Regional Hospital Laure Regional Hospital Laure Regional Hospital Section				n, give street and numbe			4b. City, To	own, or Lo	ocation of [Death		
Third Discourse Control of the Contr				_			Laurel					F	rince G	eorge	's	
214-31-2023 XI N 2					ne (In vrs. la	et hirthday)	If Linde	r 1 Vear	If Linder 2	24Hrs 1	B Date of Ric	th/MM/	יחחייייייייי	9 Birth	oplace (State or	
The state of benefits of the state of benefits and the state of the state of the st										Min.				Foreign	1	
Social State State	Director		214-31-2023	1X M 2 F	30) Yı	rs.				June 9	,19	80	Cou	ntry) Maryland	
Maryland Baltimore Dundalk 1 Vivo 2 No Note of Note																
March 2 Art District Dunchal K Top Code Top			10a. State 10b. County		10c. City, 7	Town or Loca	ation							İ		
Second Comment Comme	p	_	Maryland Balt	imore		Dun	dalk								1 Yes 2 XNo	
Second Comment Comme	rylau 14-f s	용	4			25001		Code		_	10	0g. Citi	zen of Wha	at Coun	try?	
Second Control Contr	e Ma or 28	ire	9150 Crawhatton	Poad				212	າວວ				TICA			
Second Control Contr	th th 23a notif	_				1 40 14				0./.0	f . V N				Indian Diank	
Second Control Contr	th wi	0										-			an indian, black,	
Secretarian Part Comment Part Comment Part Comment Part Comment Part Comment Part	deal deal	ַ בָּ		1 Yes	2 X No			•						1	• •	
Secretarian Part Comment Part Comment Part Comment Part Comment Part Comment Part	after all, incr		3 Widowed 4 Divo	or Dates:												
Secretarian Part Comment Part Comment Part Comment Part Comment Part Comment Part	ours atur		15. Decedent's Education (Spec	ify only highest grade co	mpleted)							16b. k	Kind of Bus	iness/In	dustry	
Secretarian Part Comment Part Comment Part Comment Part Comment Part Comment Part	72 h	ete	Elementary/Secondary (0-12)	College (1-4 o	r 5+)	during	1103101 4401	ang mo. L	20 NO1 43	o rourou	,					
Secretarian Part Comment Part Comment Part Comment Part Comment Part Comment Part	O30	ď	12 years			Iro	nworke	er				L	ocal	16		
Secretarian Part Comment Part Comment Part Comment Part Comment Part Comment Part	S-0	ပ္ပ	17. Father's Name (First, Middle, I	Last)				18	3.Mother's 1	Name (Fi	rst, Middle, N	V laiden	Surname)			
Secretarian Part Comment Part Comment Part Comment Part Comment Part Comment Part	275 e fill tal H ked		Roger Lee Mayle	s				M	Mary I	Patr	icia H	atc:	hell			
Secretarian Part Comment Part Comment Part Comment Part Comment Part Comment Part	21. Wen Men		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailii	ng Address	(Street a	and Numbe	er or Rura	al Route Num	ber, Ci	ity or Town	, State,	Zip Code)	
Secretarian Part Comment Part Comment Part Comment Part Comment Part Comment Part	2 sho and 27 is mati	-	Kelly Mayles	wife	<u> </u>	8159	Gravi	naver	n Road	đ. D	undalk	, Ma	rvlan	đ:	21222	
Secretarian Part Comment Part Comment Part Comment Part Comment Part Comment Part	and and transfer											-			own, State	
Part II Free The disease is Complications that caused the death Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List city one death Complications are that caused the death Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respir	of H	1	1 XBurial 2 Cremation	3 Removal from S								D	nd-11e	Mar	Fac [170	
Part II Free The disease is Complications that caused the death Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List city one death Complications are that caused the death Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respir	Pag Pag nent ant:		4 Donation 5 Other Spe	ecify:	Oak			-		•				•		
Part II Free The disease is Complications that caused the death Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List city one death Complications are that caused the death Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Diplor enter the mode of dying, such as cardiac or respir	alt mit. partu port		21. Signature of Funeral Service L	icensee	. 01	22. C	Name and	Address o	of Facility	l Ho	mo Of	Dun	るっした	Dλ		
Physician Medical Examiner 1970 Agrouped and property an	w 597			Conn	lle	$\sqrt{17}$	110 Sc	oller	's Poi	int 1	Road.	Dun	dalk.	Md	21222	
The standard of the standard o	Physician	75.5			d the death.	o not enter	the mode of	dying, su	uch as card	diac or re	spiratory arre	est, sho	ock, or hear	t		
The condition resulting in death) Due to (or as a consequence of): Due t	/Medical		2000.0		e	Tools										
Sequentially list conditions, far y, leading to light indicated cause, Enter Underlying Cause (light and indicated events resulting in clearly Last and indicated events resulting in clear to the control of their Control of their Control of their Control of their Control of their Control of their Control of their Control of their Control of their Control of their Control of their Control of their Control of their Control of their Control of their Control of their Control of their Control of	Examiner													_	-	
The contribution of the complete cause of the contribution of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the caus				h												
UNPENDED AMENDED AME		ē		Due to (or as a con	sequence of)	:										
UNPENDED AMENDED AME		듣	cause. Enter Underlying Cause	C.											3 24	
UNPENDED AMENDED AME	=	xar		Due to (or as a con	sequence of)	:									Č	
Past 12 months?	cuted nd trans			d												
Past 12 months?	exe ian a	lica	UNPENDED	AMENDED												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. A Pregnant at time of death S Other (Specify)	60, ite be hysic bur	Nec	IF FFMALE:	23c. If yes, outco	ome of pregna	ancv			-	_		230	d. Date of d	eliv e ry		
29b. Signature and title of certifier O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	87(tifica tifica ng pl	lu/	23b. Was decedent pregnant in the		J		etal death	3	Ectopic pr	regnancy	,		Month	Da	ay Year	
29b. Signature and title of certifier O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	x 6 h cer tendi use	icia		,	at time of dea			fy)								
29b. Signature and title of certifier O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	BO; deatl he ath	ıys	1 Yes 2 No 9 Unkr	own 9 Unknown								İ				
29b. Signature and title of certifier O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	o. I t the by tl		Part II. Other significant condition	ons contributing to dea	th but not res	sulting in the	underlying	cause giv	en in Part I	l.	23e. Did to	bacco	use contrib	ute to th	ne cause of death?	
29b. Signature and title of certifier O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	P.(1 Yes	2 🗸	No 3	Proba	ably 4 Unknown	
29b. Signature and title of certifier O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	quire quire and b	ted								- J	24a. Was a	an	I 24b. W	ere auto	opsy findings available	
29b. Signature and title of certifier 29c. License number O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	OFC IW re as be	ᇛ									autop	sy	pri	ior to co		
29b. Signature and title of certifier 29c. License number O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	lec he la ate h	티													2 No	
29b. Signature and title of certifier 29c. License number O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	n: 1		25. Was case referred to medical				2	6.Place of	f Death (Ch	heck only	one)					
29b. Signature and title of certifier 29c. License number O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	/ita sicia sis ce lirect			Hospital: 1 Inpat	ient 2 🗸 E	ER/Outpatier	nt 3 DC	OA O	ther ₄ N	tursing H	lome 5	Reside	nce 6	Other:		
29b. Signature and title of certifier 29c. License number O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Phy Phy ter th			28a. Date of In	jury	28b. Time of	Injury 2	Bc. Injury	at Work?	28	d. Describe h	now inju	iry occurre	a		
29b. Signature and title of certifier 29c. License number O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Ming h. Af	<u>.</u>	1 Natural 5 Pendi	na Dec 20, 201	, Year)	1500 hrs		1 ✓ Ye	s 2 No	。La	rge gener	ator f	ell on the	e subj	ect	
29b. Signature and title of certifier 29c. License number O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	SiO After dear dear	펺		tigation	laire. At hav	ma form atr	not footon	office buil	Idina ata	20	f Location (S	troot o	nd Number	or Pur	al Poute Number City	
29b. Signature and title of certifier 29c. License number O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ivi lor/ after Dire	Į.	outdo	not be			bet, factory,	Office buil	iuliig, etc.							
29b. Signature and title of certifier 29c. License number O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	pital ours	Çe	4 Homicide	(Specify) Co	nstruction	n site				Bio	lg 6704 Tay	/lor Str	reet, Ft M	eade, r	VID .	
29b. Signature and title of certifier 29c. License number O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	E Hos 24 h Fun		(Check only	•												
29b. Signature and title of certifier 29c. License number O.C.M.E. December 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	o the stription of the	ğ	one) 2 Medical Exam			d/or investig	ation, in my	opinion, c	death occur	rred at th	e time, date a	and pla	ice, and du	e to the	cause(s)	
30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	F 3 F 8	Me	29b. Signature and title of certifier				29c.	License r	number			29d. [Date signed	(Mont	h, Day, Year)	
Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			()_M)					O.C.M	.E.			Dec	ember 2	1, 20	10	
Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			20 Name and address of service	who completed course of	dooth /lion *	232)										
31 Date filed (Mooth, Day Year) 32 Registrar's Signature							1 Penn S	treet F	Baltimore	e. MD	21201					
State 31. Date tiled (Month, Day Year) 32. Registrars signature								., COL, L		J,						
			31. Date filed (Month, Day Year)	32. Registr	ars Signatur	e										

10

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#30perDVR,G910,12/22/2010,WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 2310 M)ec Jone OIC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AT-EDERIC rederic Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 M 2 🗆 F Months 83 Director March 5, 1928 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No redex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral osema 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc ò 1 Never Married 2 Married 2 No þ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced "natural" Completed white Year or Dates. is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle 17. Father's Name (First, Middle, Last) Surname ည 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21780 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 6311 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method Disposition Date WK 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signatur of Fund al Service Licensee 22. Name and Address Lility JR-55C40 1832 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death onset and Death Immediate Cause (Final Physician montra disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Other (specify) Pregnant at time of death 1 Yes 9 Unkr been signed by the a should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the sector, page 2 s autopsy director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after deau.

To the Funeral Director: After this completed filled in by the funeral di Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? iniury 5 \square Pending 2 🗌 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature ar e of certifier 2 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) Robert Kaufman 300 West Ninth St. Frederick, MD 21701 31. Date filed (Month, Day, 32. Registrar's Signature State DEC 2010 22 ark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MANALAD Month Physician/ MARIO Year **201** 9:00 AM DEC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore 8. Date of Birth 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F Months Davs Hours Min. April Day Ye , 1945 Philippiles Reija, 220-57-7154 Director 65 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 items 23a Funeral 21214 United States 4905 Harford Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 0 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣No Specify: If Yes, Give Year or Dates Specify: Filipino "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) Bank Associate Banking Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked of permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any fininy or other traumatic eve and fininy or other traumatic ever ည Anita Pacson Vicencio Mauro Franco Manalad (wife) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21214 4905 Harford Road Mrs.Caridad Dela Cruz Manalad 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Jown State (Harford County) Reas Fure al Crarel and Craration Services, Inc. 1 Burial 2 Cremation 3 Removal from State Thursday 4 ☐ Donation 5 ☐ Other (Specify) Dec. 23, 2010 Forest Hill, Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Peaceful Alienatives Funeral and Cremation Center, P.A. an Lic. #100677 Timonium, Maryland 21093-2215 2325 York Road 23a. Pal 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINIOMA Physician/ LUNG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctonic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director, After thi completed filled in by the funeral Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury Natural 5 Pending Investigation 2 Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier D70031 MD Manajan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) É. UNIVERSITY PARRWAY, BALTIMOREMOZIZE VRINDA 201 MANAJAN

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

2010

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:45 a^{M} December 2010 HELEN PATRICIA MATE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Baltimore Timonium 8. Date of Birth (Month, Day, Yo October 22 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funera! Days Hours Country) Mary Land 1 □ M 2 💢 F Director 218-30-5131 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 ☐ No Maryland N/A South Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 607 East Randall Street 21230 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 2 No þ 1 Never Married 2 Married Yes 1 Yes 2 No Specify: White If Yes, Give Year or Dates. Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10 Teachers Aide Baltimore City Schools Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Welsh Martin H. Rogers Theresa M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607Fast Randall Street, Baltimore, Maryland 21230 Teresa M. Dworek (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cedar, Hill Genetery 23,2010 4 Donation 5 Other (Specify) Brooklyn Park, Maryland Signature of Funeral Service Licens McCully-Polyniak Funeral Home P.A. 130 Fast Fort Avenue. Baltimore Maryland art 1. Enter the disease, or complic flors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one, ause on each line. Interval Between Onset and Death mmediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year eral Director, After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached i 1 ☐ Yes ∠ µ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manger of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury (Month, Day, Year) Natural Accident iniury 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital within 24 hours a

To the Funeral C

completed filled Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Aedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29c. License number person who completed cause of death (Item 23a) (Type, Print) 3001 32. Registrar's S State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12-19-2010 Physician/ 8:45A Madeline A. Notarange Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Parkville Balto. 0akcrest If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 ☐ M 2 🛣 F (Month, Day, Year) 7-13-1922 Maryland Director 88 214-14-9917 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location hours after death with the Maryland Director Md. Balto. Parkville 1 Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō pernit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 Funeral 8810 Walther Blvd.Apt.3404 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?,

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Life Insurance Co. Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mabel Offley Ignatius Ayd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, Md. 21234 8810 Walther Blvd. Apt.3404 Nicholas Notarange Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-22-2010 Parkville, Md. Parkwood 21. Signeture of Funeral Service Livensee 22. Name and Address of Facility Schimunek Funeral Home 1 Nottingham, Md. 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) rements end Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Notatan 90 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant a Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death.

Funeral Director: After this certificate has leted filled in by the funeral director, page 2 s autopsy performe death? 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) J311 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) atville Walth 8400

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

9

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 19, Glennie Bell Nickols 2010 8:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 105 Hopewell Road Harford Churchville Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 19 , **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Tennessee 83 **Director** 211-20-2782 May Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Churchville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Hopewell Road 21028 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 5 College (1-4 or 5+) Homemaker Own Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Texie Estie May John Radford May Lepartment of Health and Important; if item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Foreman / Daughter P. O. Box 130, Perryman, Maryland, 21130 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Remo Harford Memorial Gdn: 12/23/2010 Aberdeen, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility McComas Funeral Home, P.A. Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Directo for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year the g Unknown g Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes been sir Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed this certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? ithin 24 hours after death.

• the Funeral Director Al

ompleted filled in by the fu fter death. 2 Accident
3 Suicide
4 Homicide 2 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the F

complet 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) 602 S. Atwood Road And completed cause of death (Item 23a) (Type, Print) Name and address of persor ahun Bel Air, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b&c Per FH G911 1/26/2011 JH State of Maryland / Department of Health and Mental Hygiene f - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 9.57 AM Okonkwo 2010 Catherine Nonye 250 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSDITA 11:000 Agnes If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🗓 F Months Days Hours 69 Director 369-17-8607 Nigeria Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits i and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Modical Examinar mast by notified at 1 ☐ Yes 2 ☐ No Director Catonsville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral U.S.A. 406 Misty Wood Way 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify \$ Specify: Black filed within 72 hours 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Unemployed Unemployed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be 1 permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any linjury or other traumatic evonce. ပ Ogo Ugonwaenyi Udumagana Okafor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Misty Wood Way, Catonsville, Md 21228 Obi Okonkwo Mangrover-Son Baltimore, 20b. Place of Disposition (Name of Ukn cemetery, crematory or other place) 20a. Method of Disposition Date Ukn 20c. Location - City or Town, State Lagos, Nigeria 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Family Plot 2/16/11 22. Name and Address of Facility

arch F/H West

4300 Wabash Ave, atur # Funeral Service License 21. Si Baltimore, Md 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myeloid leukernia BURGERARE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi attending physician and Due to (or as a consequence of): Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 □Yes 2 ☑No P.0. 9 ☐ Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has autopsy certificate 1 □Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ ot this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospitai or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

• Funeral Director: A pletely filled in by the fi death. 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) within 2 To the I and manner stated. Curdo Damara 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P24057 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) caton Ave, Bultimore, Damera 900 agrica

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

fall

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:30 AM **PATTERSON** ecembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Buthmore of Baltimore N/A 5. Social Security Numbe If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Hours 0171971966 **Director** 44 217-80-0199 MD Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD 1 🗌 Yes 2 💢 No BALTIMORE REISTERSTOWN 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 GLYNDON DRIVE 21136 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by ō 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hours pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ASSEMBLER MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ WILLIAM RUBIN SHIRLEY GROUPP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY RUBIN-ROLLINS/MOTHER 19 GLYNDON DRIVE, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2010 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Medical Examiner labetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last executed attending physician and Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FÉMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 1 ☐ Yes 2 ☐ No Yes To Be 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) examiner? 2 🗌 No XInpatient 2 □ Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check **Certifying Nurse** RES DOD

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who comp

Sinai Hospital

ted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MOSE Nancy Lee Palmer 3.50 M 17 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GIRN BURNIE BAUTMUPE WE ACHINGTON MEDICAL CENTE ANNE If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗚 F 68 Months 08/01/ 212 40 2146 Maryland Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County death with the Maryland 10c. City Town or Location 10d. Inside City Limits Director Marvland Anne Arundel 1 ☐ Yes 2 🖾 No Severn 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 8015 Fair Breeze Drive 21144 U.S.A. ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White Specify: Completed 3 XWidowed 4 Divorced or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Electrical Supply Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ William Doyle Hobbs Nannie Gertrude Bathgate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Page 1 and 2 Kevin Palmer / Son 434 Mall Court Millersville, Maryland 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite 1 Burial 2 Carcemation 3 Removal from State Baltimore, Maryland Bayview Crematory 12/21/2010 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service oce Gonce Funeral Service, P.A. 22. Name and Address of Facility LONZ 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER LUMG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner OBSTRUCTIVE KULMON ARY Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 🗌 Yes 2 🗹 No Other: ဂ္ Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident 24 hours after death Funeral Director; Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. 1245149 Name and address of person who completed cause of death (Item 23a) (Type, Print) en Burnie 501 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Chair	artment of Health and M	lental Hygie	ne nin lasan
		_	Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg.	
	Physicia Medic		Anne Marie Poole		2. Date of Death Month Decembe	Day 19, 2010 5:30 P M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
-	, 14		Laurel Regional Hospital	Ldurel		Prince George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	g. Birthplace (State or Foreign Country)
			Usual Residence of Decedent		Nov. 21,	1934 Massachusetts
	and show	ō	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryl 28a-f stifie	Director	MD Montgomery Burtons	ville		1 😾 Yes 2 🗌 No
	the l	<u>=</u>	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	with rs 23;	Funeral	3638 Van Horn Way	20866		USA
	death item ner n	큔	Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian,
36	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er tha Medical Examiner must be notified at , the Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 Yes 2 X No	1 ☐ Yes 2 🛛 No Specify:	110411, 0101,	Black, White, etc. Specify: White
Ş	atura cal E	etec	Tour or Dates.	dent's Usual Occupation	1	
75	an "n Medi	Completed	(Specify only highest grade completed) (Give	kind of work done during most of working NOT use retired)	ng 160	. Kind of Business Industry
7	withil giene er th			ccountant	D	ept. of Navy
Maryland 21215-0036	filed tal Hy d oth event	o Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	en Surname)
₹	Meni Meni narke	은	John R. McCormack	Anne	I. Sh	aughnessy
Mar	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	0 4	l l	ng Address (Street and Number or Rural	Route Number, City	or Town, State, Zip Code)
	and 2 s Health tem 27 other tra				lington,	
Baltimore,	Page 1 nent of l ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cernetery, cre	natory or other place)		. Location - City or Town, State
₽	permit. Page Department Important: I any injury or once.			ary's Cem. 12/2 2. Name and Address of Facility Don		awrence, MA
Ba	permit. Departr Importa any inju		1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	313 Talbott Avenue		
Ė			23a. Part 1 Enjer the disease, or complications that caused the death. Do not ent			, MD 20707 Approximate
	Enysician/	rc s	shock or heart failure. List only one cause on each line. Immediate Cause (Final	000		Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	Traceion		
	Examiner	L.	Sequentially list conditions, b.			
_	gi, id	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying			
5	and I-trans	Exar	Cause (Usease or injury that initiated events c. Due to (or as a consequence of):			
0	death certificate be executed ne attending physician and ed for use as the burial-transit	dical				
2.09	ficate g phys	/ledi	_ d			
89	certif anding use a	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy		23d. Date of delivery
Box	death	sicis	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
Ю. О.	at the	Physician/Me	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	and and the second seco	1.	
ι <u>ς</u> σ.	es tha signed be de	P	Farth. Other significant conditions continuating to death but not resulting in the i	inderlying cause given in Part I.		o use contribute to the cause of death?
ğ	requir	etec				2 No 3 Probably 4 Unknown
ဝင္ပ	has ge 2 s	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
Ĩ	n: Th		25. Was case referred to medical	00.00	performed 1 Yes 2	No 1 ☐ Yes 2 🗶 No
Z ta	/sicia	To Be	examiner? 1 ☐ Yes 2 🕱 No Hospital: 1 🛣 Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Check of Death)		a [] au
6	g Phy er this	Fe: T	27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at 28	Bd. Describe how inj	6 ☐ Other (Specify) ury occurred
o	endin sath. or; Aft he fur	fica	2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 2	8f. Location (Street a	and Number or Rural Route Number, te)
5	pital o		On a viving a Market Black Transfer			
	e Hos	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the control of	tigation, in my opinion, death occurred at the	he time date and pla	ce and due to the cause(s) and manner stated
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t		29b. Signature and title of certifier	29c. License number		e(s) and manner as stated. Date signed (Month, Day, Year)
			· UL	D0067210		12/19/11
	, 0		30. Name and address of person who completed cause of death (Item 23a) (Type, F	rint) 7300	Van Dus	sen Road
	19		30. Name and addiess of person who completed cause of death (Item 23a) (Type, F Rohit Khirbat, MD Laurel Region	al Hospital Lau	irel, MI	20707
	Stat Registra	e r	31. Date filed (Month, Day Year) DEC 2 2 2010 Queen 3. Register's Sign Jure			